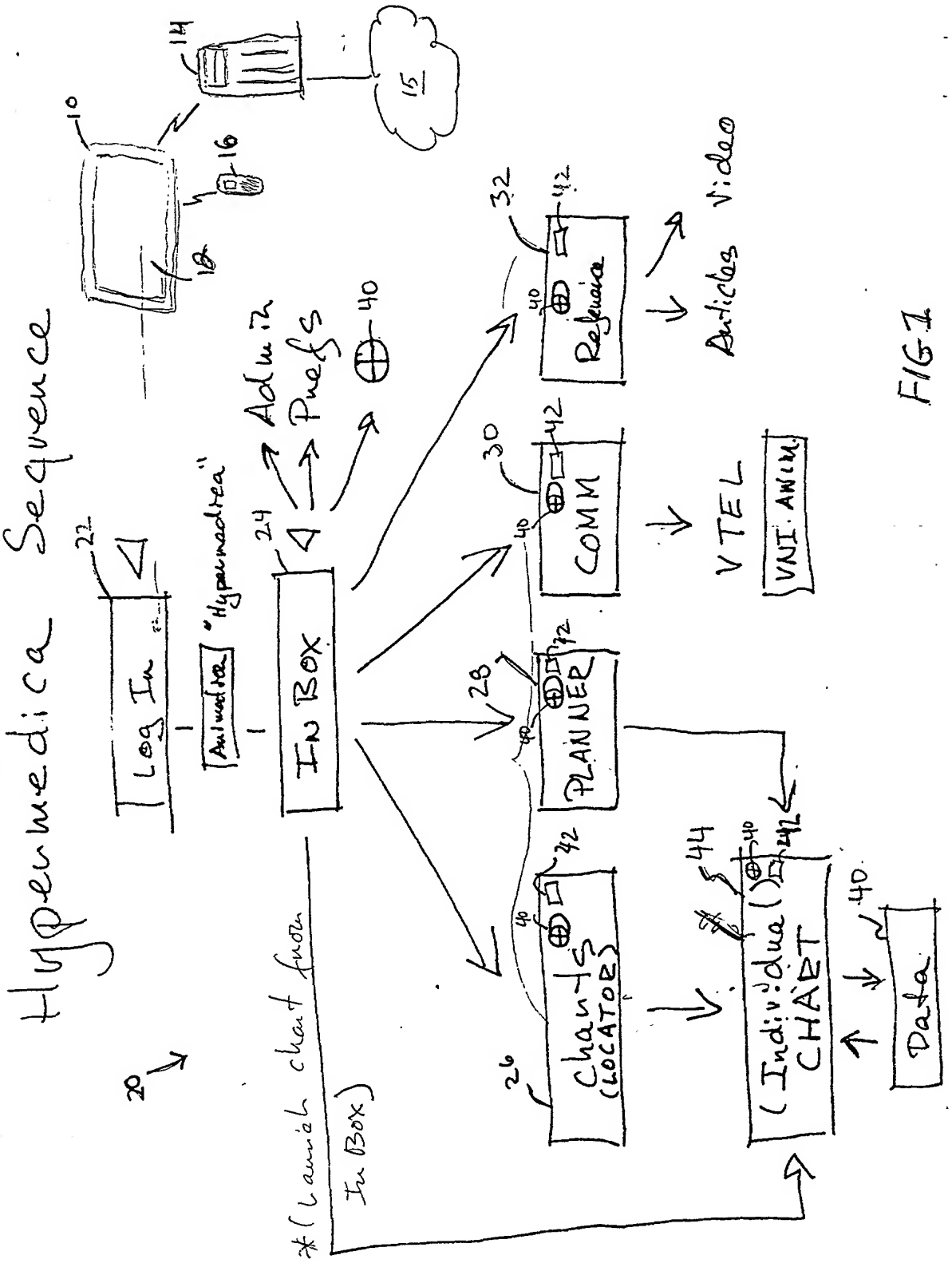

Hypermedica Sequence
20
Log In
22
Animation
"Hypermedica"
In BOX
24
Admin
Prefs
40
10
14
16
18
15
32
42
Reference
Articles
Video
30
COMM
VTEL
VNI AWIM
28
PLANNER
Charts
(LOCATORS)
26
(Individual)
CHART
44
Data
*(Launch chart from
In Box)

FIG 1

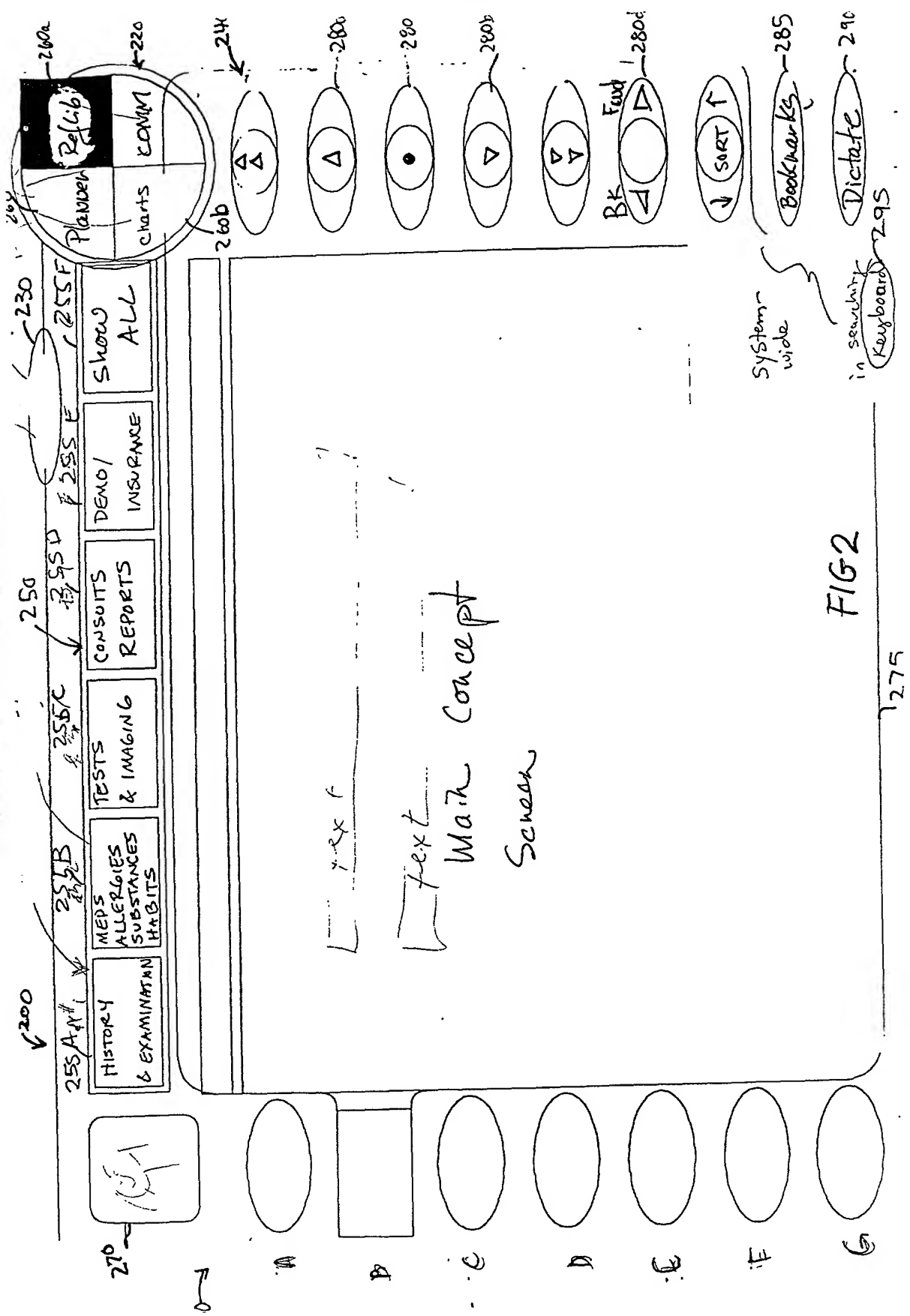

200
255A
HISTORY & EXAMINATION
MEDS ALLERGIES SUBSTANCES HABITS
255B
TESTS & IMAGING
255C
CONSULTS REPORTS
255D
DEMO/ INSURANCE
255E
SHOW ALL
255F
230
250
260a
Refer
Planner
Charts
Comm
220
240
260b
280a
280
280b
280c
Fwd
Bk
SORT
285
Bookmarks
290
Dictate
295
System-wide
In secondary Keyboard
270
A
B
C
D
E
F
G
Text
Main Concept
Screen
275

FIG2

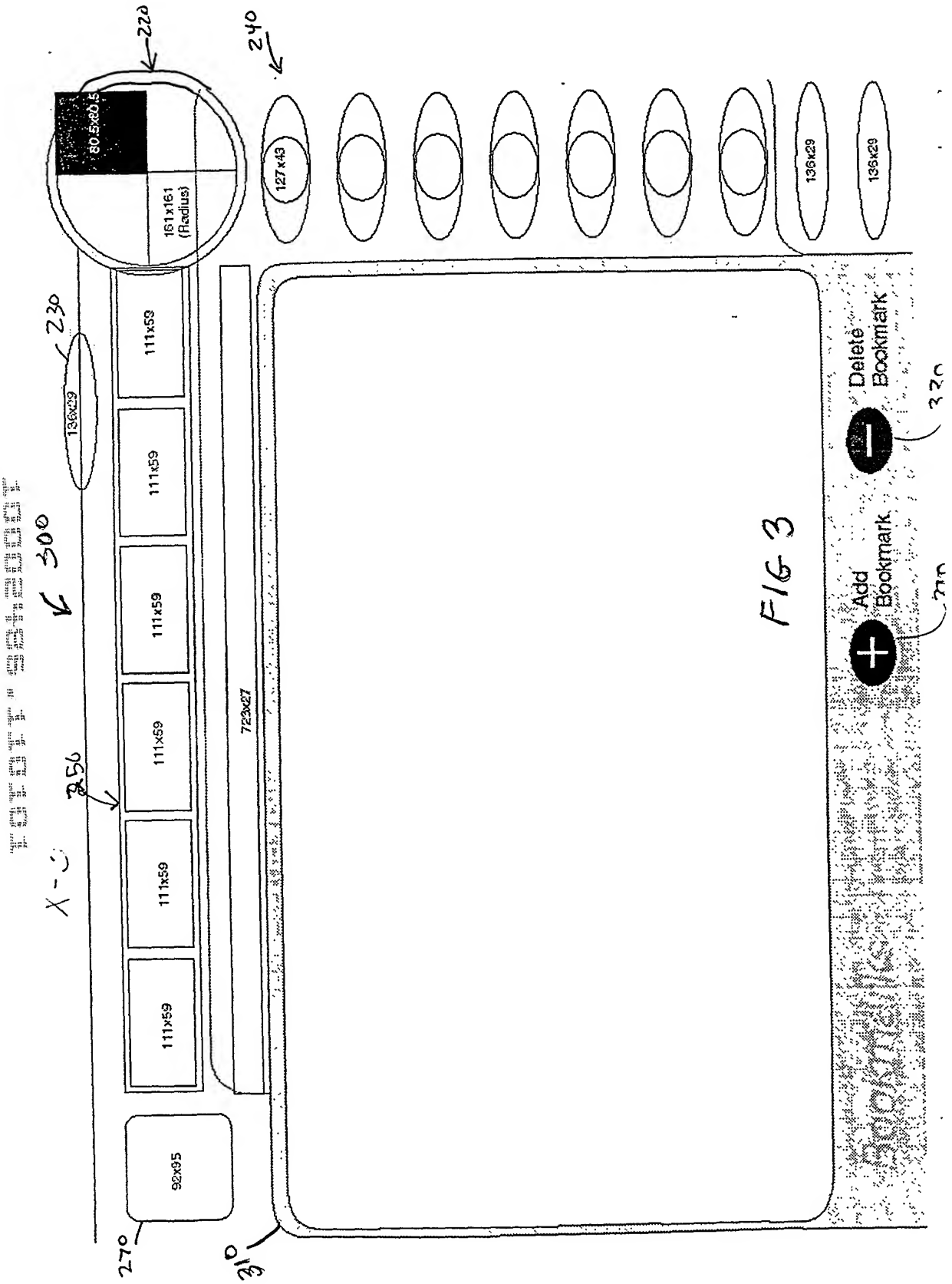
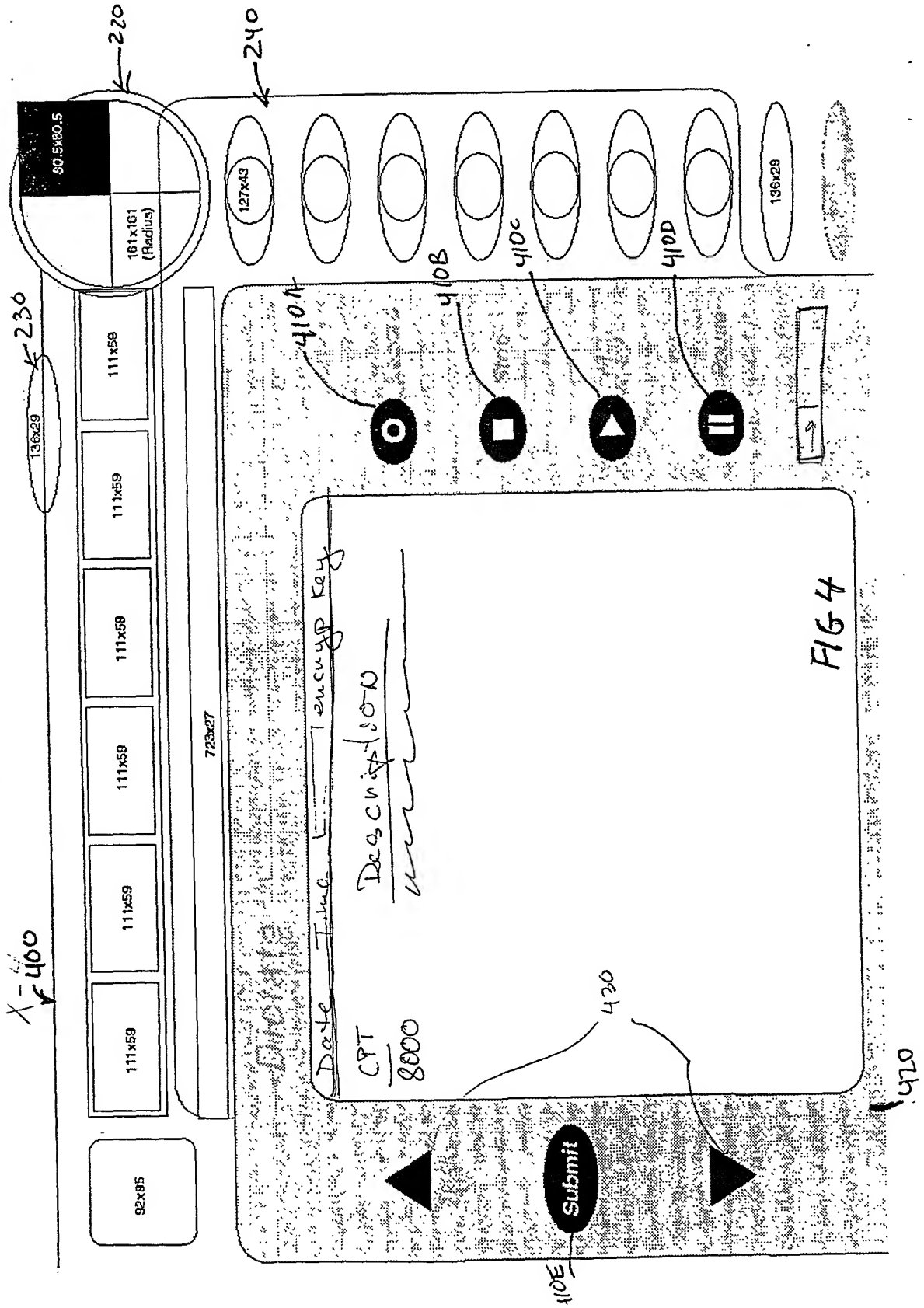

220
240
80.5x80.5
161x161 (Radius)
127x43
136x29
136x29
230
136x29
111x59
111x59
111x59
111x59
111x59
723x27
92x95
300
250
270
310
Delete Bookmark
320
Add Bookmark
330

FIG 3


220
240
230
400
410A
410B
410C
410D
410E
420
80.5x80.5
161x161 (Radius)
127x43
136x29
111x59
723x27
92x85
Submit
CPT
8000
Date
Time
Description
Encounter Key
FIG 4

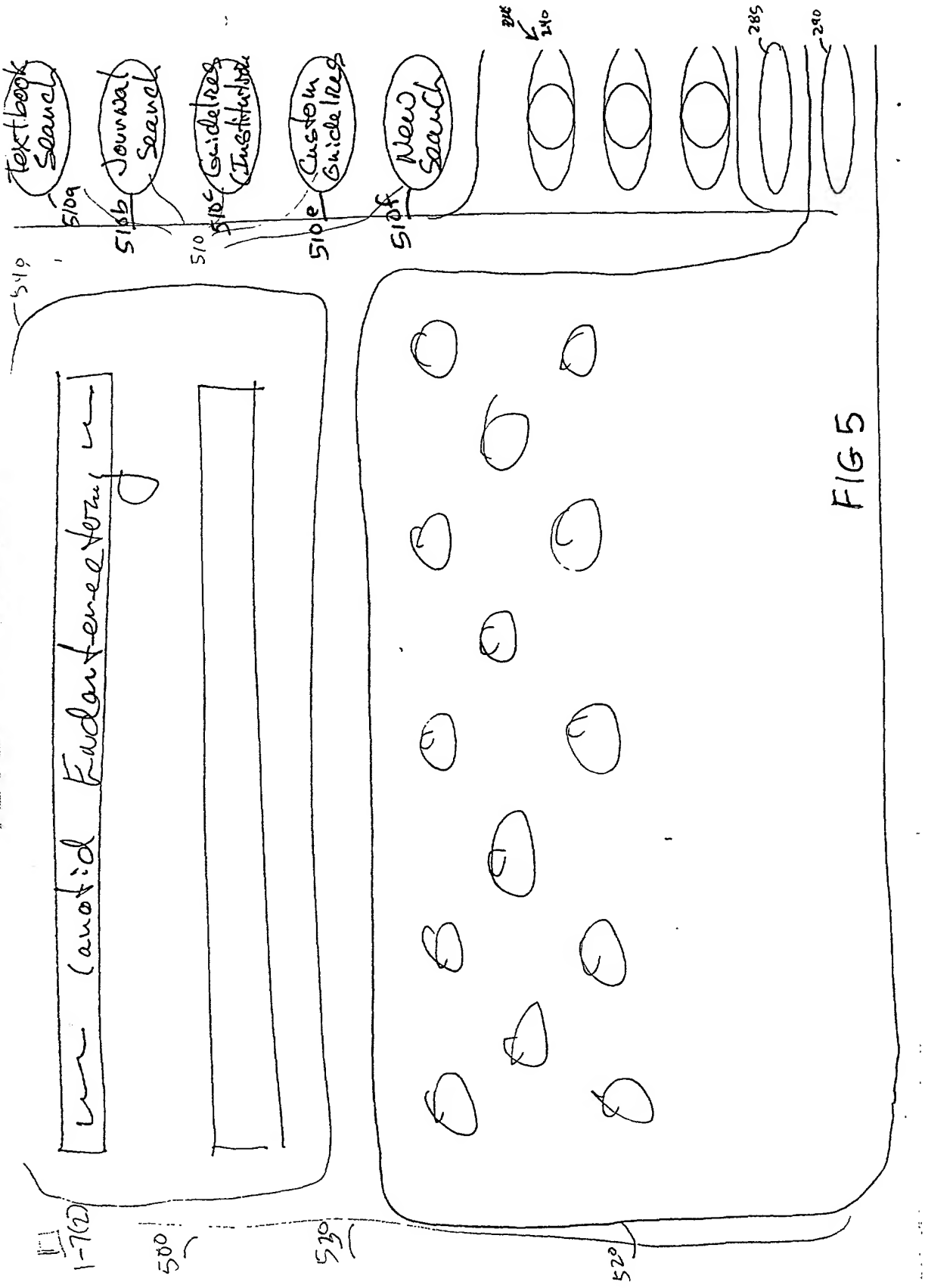

Textbook Search
Journal Search
Guidelines Institutional
Custom Guidelines
New Search
510
510a
510b
510c
510e
510f
510g
240
285
290
500
520
520
Carotid Endarterectomy

FIG 5

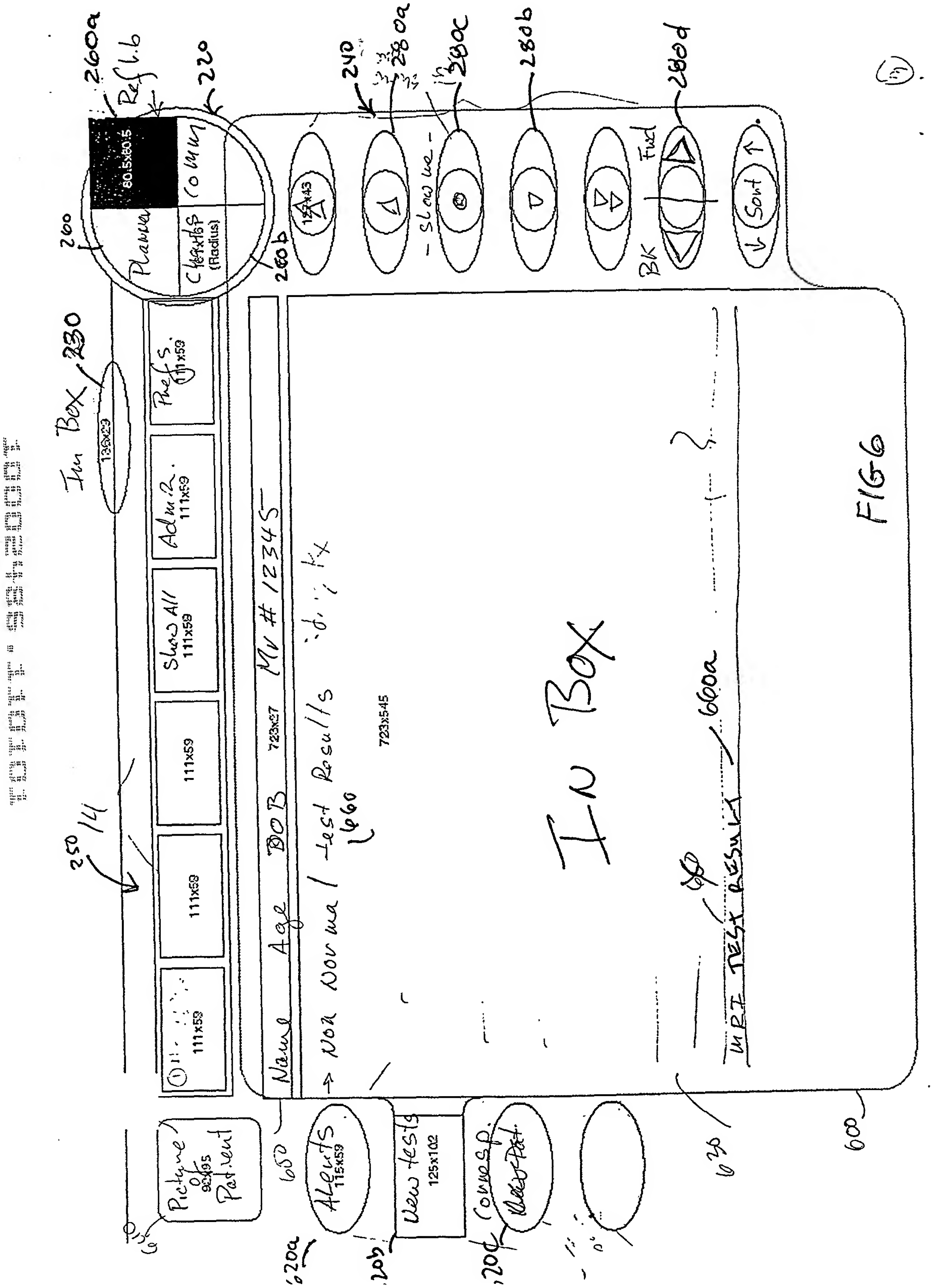

In Box
136x29
230
200
220
260a
260b
240
280a
280b
280c
280d
250
14
Planner
80.5x80.5
Commu
Charts
(Radius)
Prefs.
111x59
Admin
Show All
111x59
111x59
111x59
111x59
Name
Age
DOB
MR # 12345
723x27
Non Normal Test Results
660
723x545
IN BOX
660a
MRI TEST RESULT
Picture of Patient
92x95
Alerts
115x59
New tests
125x102
Corresp.
Sort
Fwd
BK
slow me
650
630
600
620a
205
20c

FIG 6

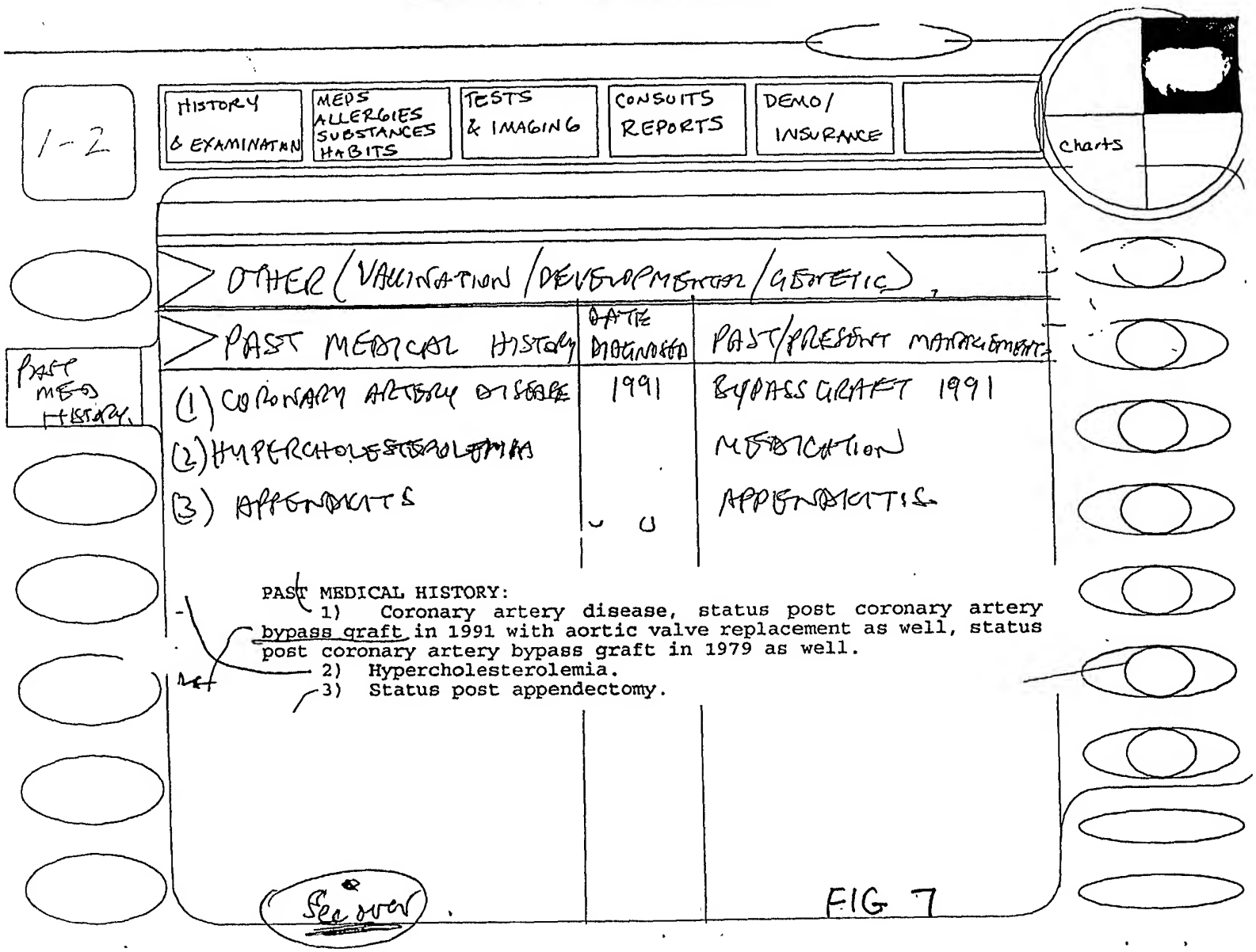

1-2
HISTORY & EXAMINATION
MEDS ALLERGIES SUBSTANCES HABITS
TESTS & IMAGING
CONSULTS REPORTS
DEMO/ INSURANCE
charts
OTHER (VALUATION / DEVELOPMENTAL / GENETIC)
PAST MEDICAL HISTORY
DATE DIAGNOSED
PAST/PRESENT MANAGEMENT
PAST MED HISTORY
(1) CORONARY ARTERY DISEASE
1991
BYPASS GRAFT 1991
(2) HYPERCHOLESTEROLEMIA
MEDICATION
(3) APPENDICITIS
APPENDICITIS
PAST MEDICAL HISTORY:
1) Coronary artery disease, status post coronary artery bypass graft in 1991 with aortic valve replacement as well, status post coronary artery bypass graft in 1979 as well.
2) Hypercholesterolemia.
3) Status post appendectomy.
See over

FIG 7

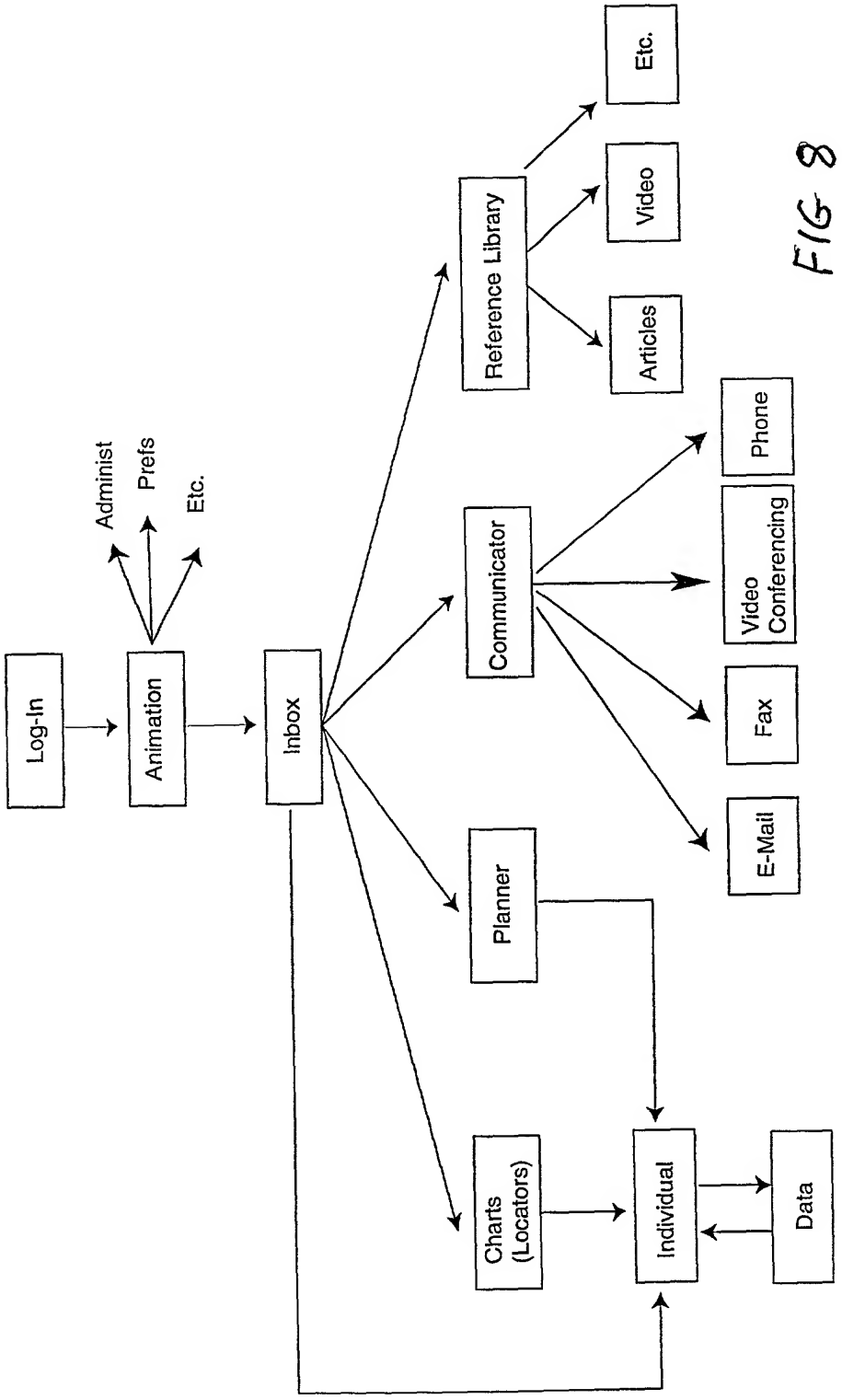

Log-In
Animation
Administ
Prefs
Etc.
Inbox
Reference Library
Etc.
Video
Articles
Communicator
Phone
Video Conferencing
Fax
E-Mail
Planner
Charts (Locators)
Individual
Data

FIG 8

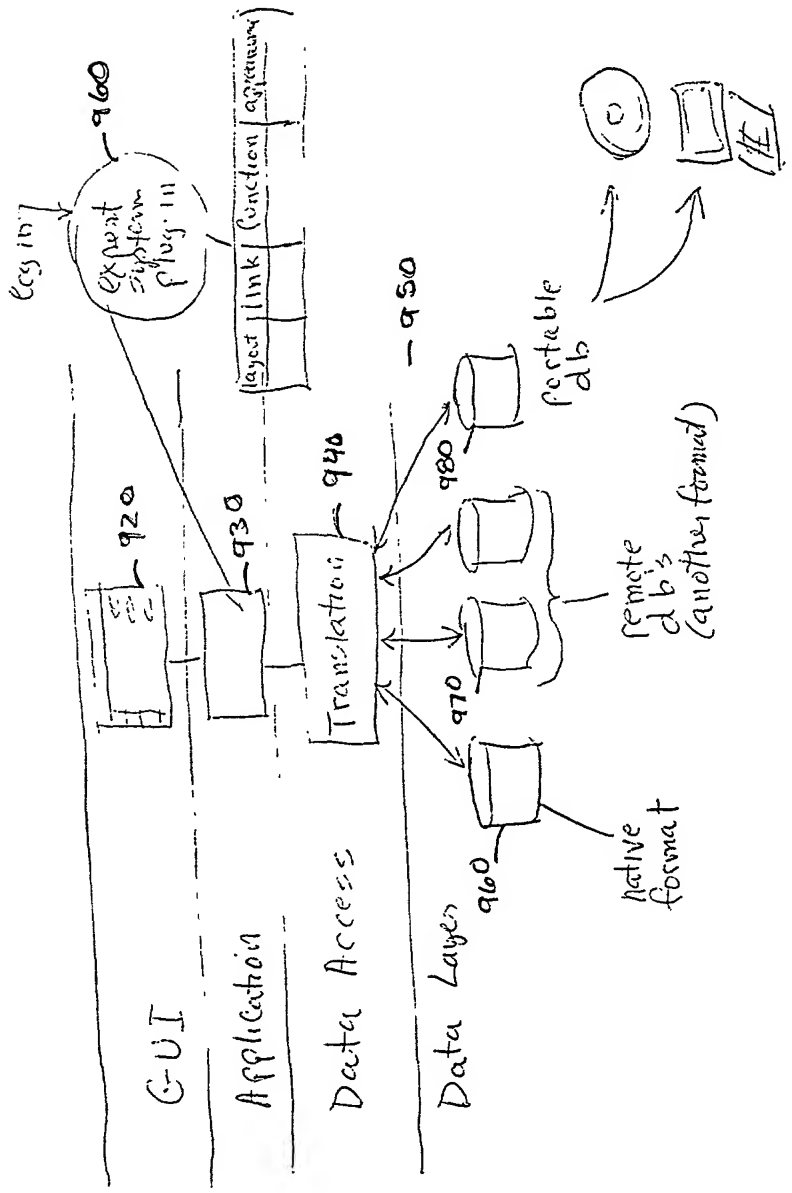

960
key in
Export system plug-in
layer
link
function
agreement
920
930
940
950
Translation
980
portable db
970
remote db's (another format)
native format
960
GUI
Application
Data Access
Data Layer

FIG 9

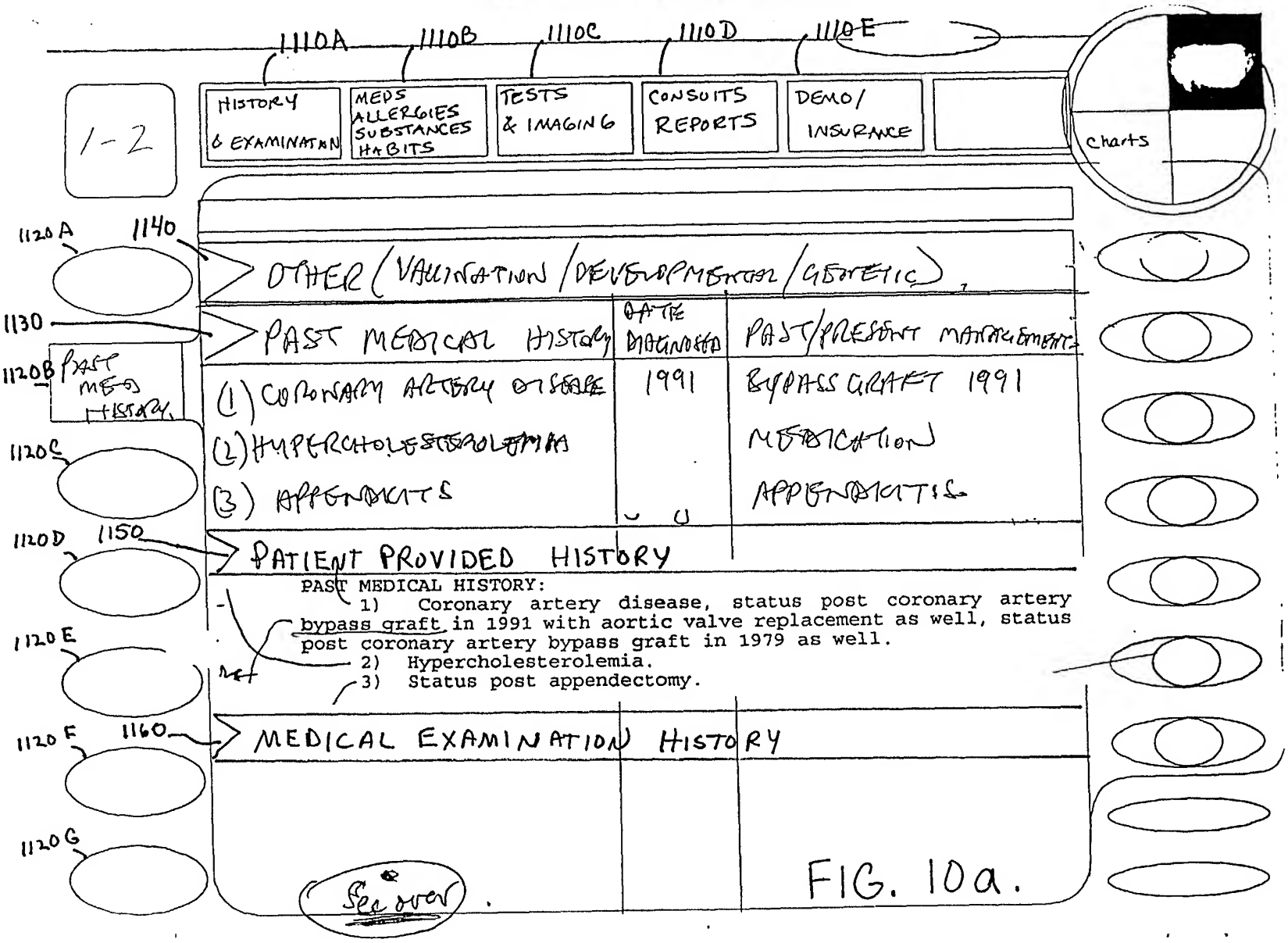


FIG. 10a.

Title: MULTIMEDIA COMPUTERIZED PATIENT RECORD SYSTEM
Inventor: Manoucher Gueramy et al.
Atty. Ref. No.: 6766-000004

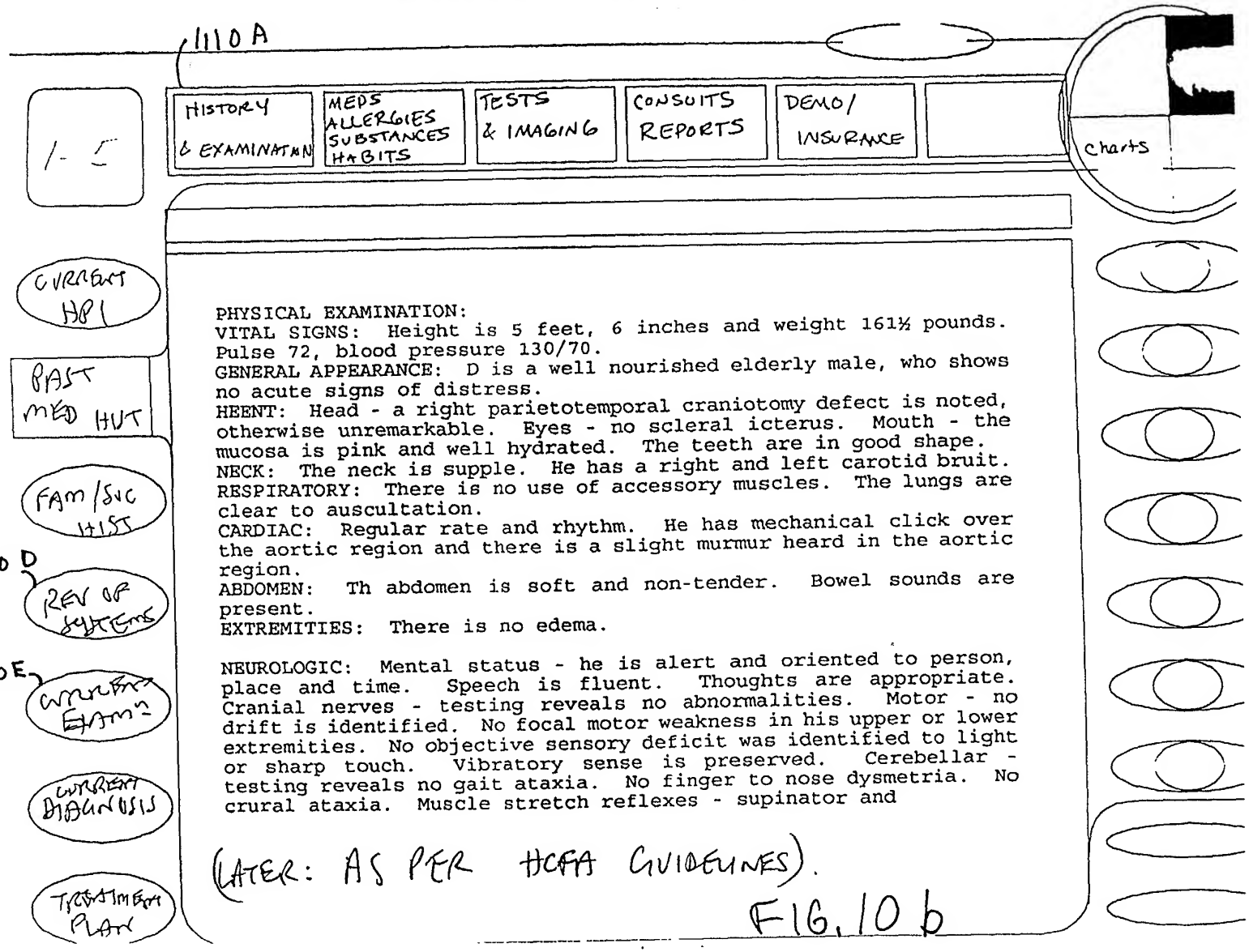
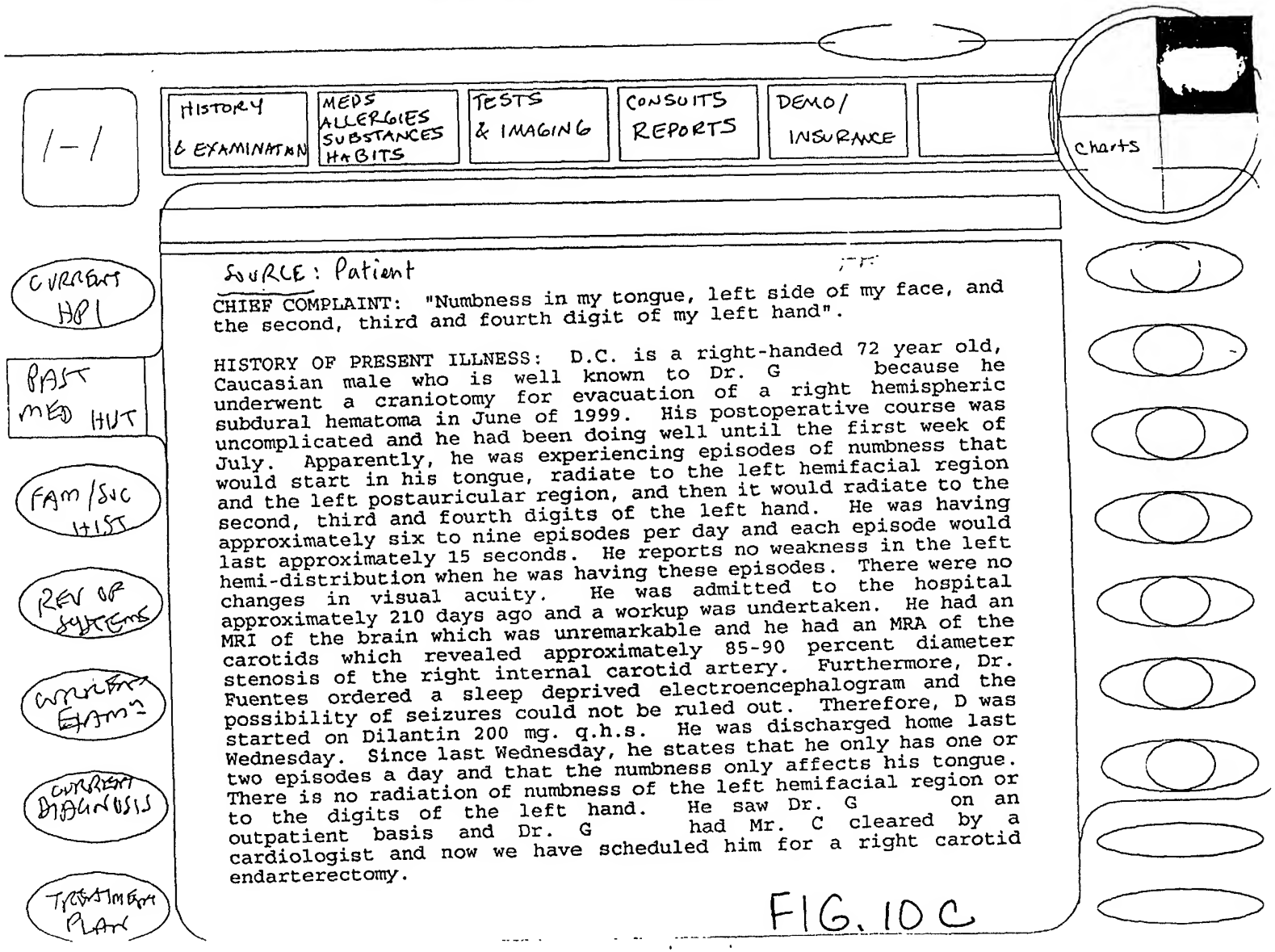


FIG. 10 b

Title: MULTIMEDIA COMPUTERIZED PATIENT RECORD SYSTEM
Inventor: Manoucher Gueramy et al.
Atty. Ref. No.: 6766-000004



SOURCE: Patient

CHIEF COMPLAINT: "Numbness in my tongue, left side of my face, and the second, third and fourth digit of my left hand".

HISTORY OF PRESENT ILLNESS: D.C. is a right-handed 72 year old, Caucasian male who is well known to Dr. G because he underwent a craniotomy for evacuation of a right hemispheric subdural hematoma in June of 1999. His postoperative course was uncomplicated and he had been doing well until the first week of July. Apparently, he was experiencing episodes of numbness that would start in his tongue, radiate to the left hemifacial region and the left postauricular region, and then it would radiate to the second, third and fourth digits of the left hand. He was having approximately six to nine episodes per day and each episode would last approximately 15 seconds. He reports no weakness in the left hemi-distribution when he was having these episodes. There were no changes in visual acuity. He was admitted to the hospital approximately 210 days ago and a workup was undertaken. He had an MRI of the brain which was unremarkable and he had an MRA of the carotids which revealed approximately 85-90 percent diameter stenosis of the right internal carotid artery. Furthermore, Dr. Fuentes ordered a sleep deprived electroencephalogram and the possibility of seizures could not be ruled out. Therefore, D was started on Dilantin 200 mg. q.h.s. He was discharged home last Wednesday. Since last Wednesday, he states that he only has one or two episodes a day and that the numbness only affects his tongue. There is no radiation of numbness of the left hemifacial region or to the digits of the left hand. He saw Dr. G on an outpatient basis and Dr. G had Mr. C cleared by a cardiologist and now we have scheduled him for a right carotid endarterectomy.

FIG. 10C

PATIENT SCREEN

PAST/MEDICAL/HISTORY
SUBSCREEN

GENETIC INFORMATION
FAMILY HISTORY OF GENETIC DISEASES
HLA/TISSUE TYPING (CROSS REF. TO LABS)
OTHER INFORMATION

DEVELOPMENTAL HISTORY
PRENATAL/BIRTH PROBLEMS
"MILESTONES"
INFANT/CHILD DEVELOPMENT PROBLEMS
OTHER ISSUES.

VACCINATION HISTORY./SCHEDULE

SHOW ALL.

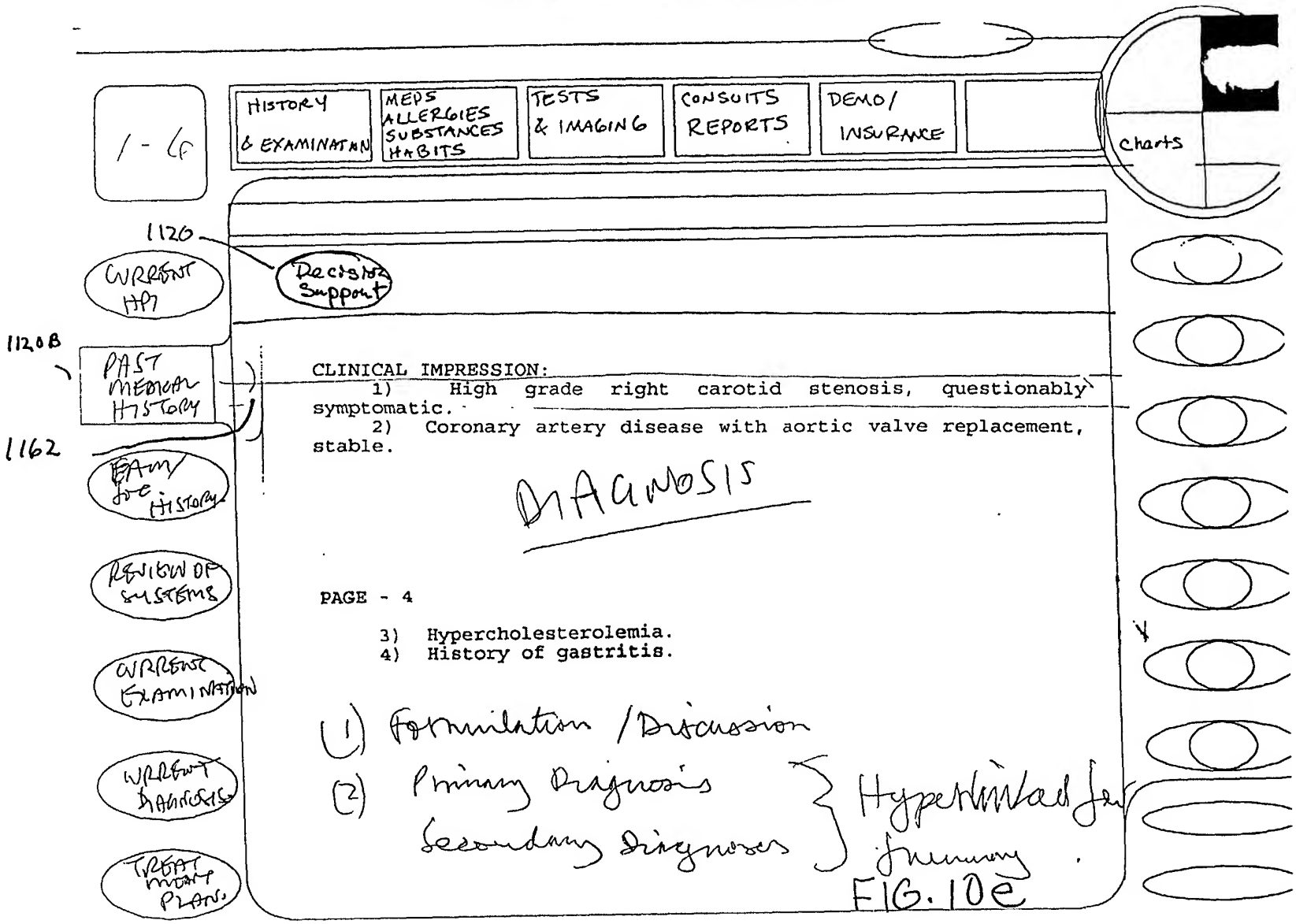
GENETIC INFORMATION

DEVELOPMENTAL HISTORY.

VACCINATION HISTORY

FIG. 10d

Title: MULTIMEDIA COMPUTERIZED PATIENT RECORD SYSTEM
Inventor: Manoucher Gueramy et al.
Atty. Ref. No.: 6766-000004
13/33



Title: MULTIMEDIA COMPUTERIZED PATIENT RECORD SYSTEM
Inventor: Manoucher Gueramy et al.
Atty. Ref. No.: 6766-000004
14/33

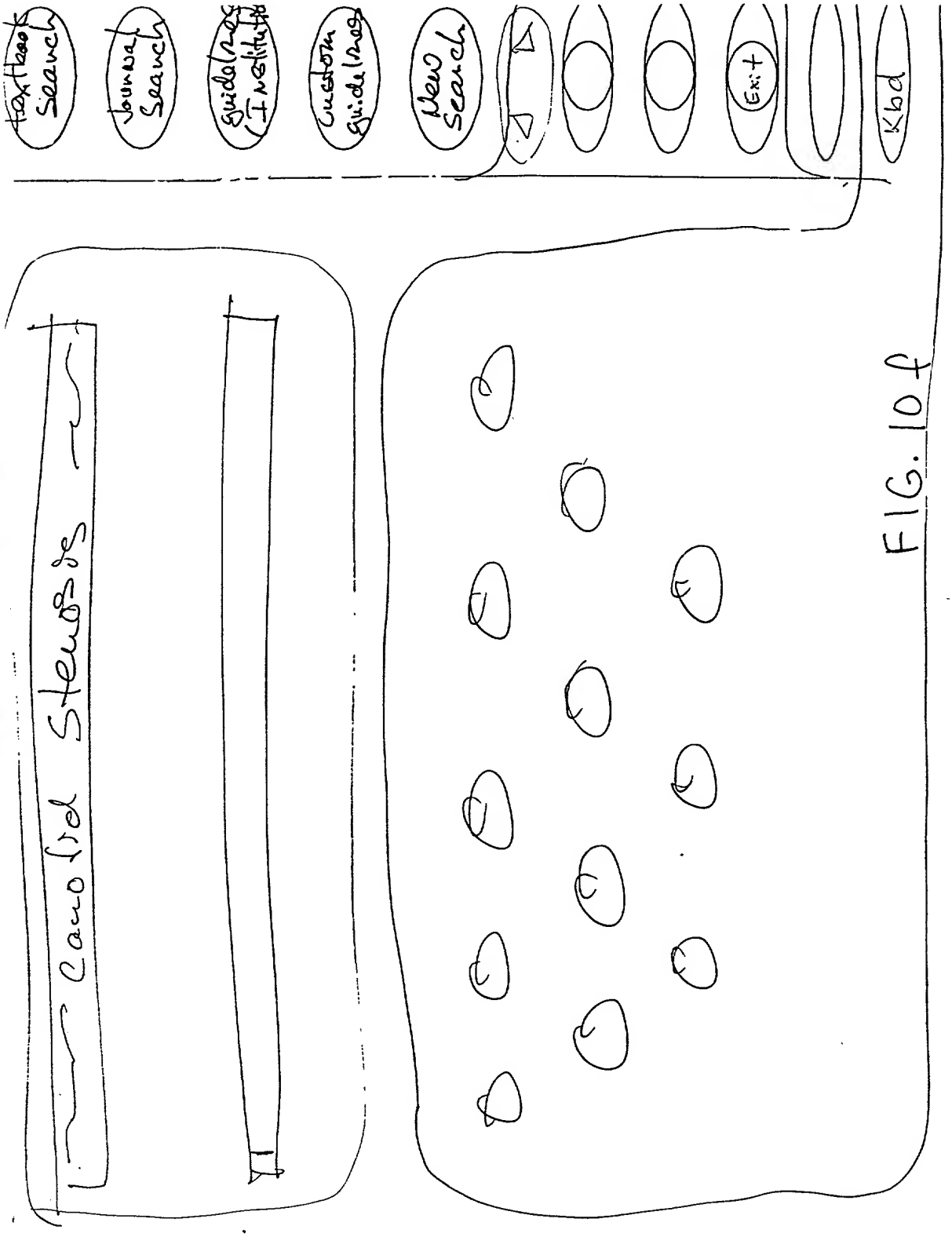

Textbook Search
Journal Search
Guidelines Institute
Custom Guidelines
New Search
Exit
Kbd
Carotid Stenosis

FIG. 10f

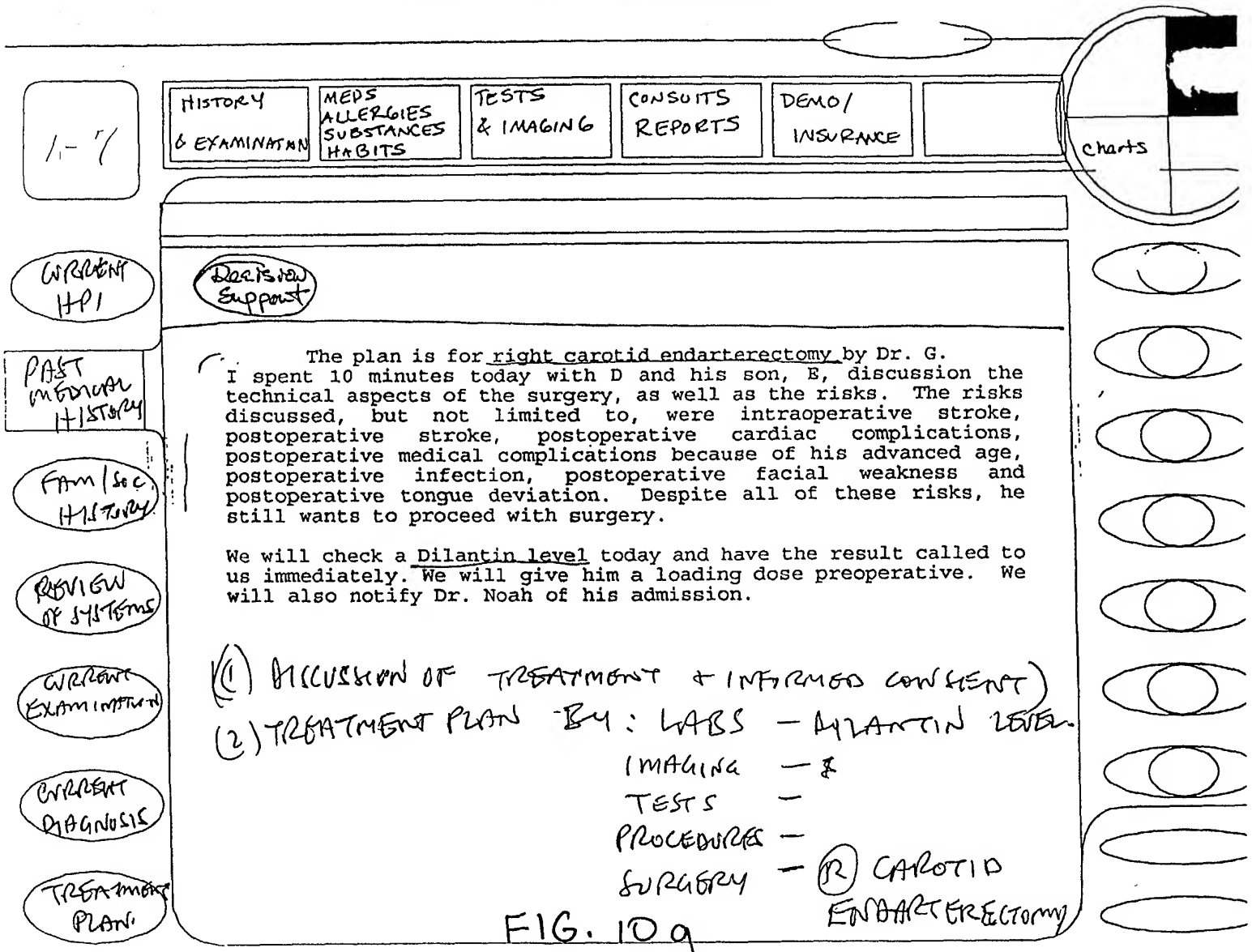


FIG. 10g

Title: MULTIMEDIA COMPUTERIZED PATIENT RECORD SYSTEM
Inventor: Manoucher Gueramy et al.
Atty. Ref. No.: 6766-000004
16/33

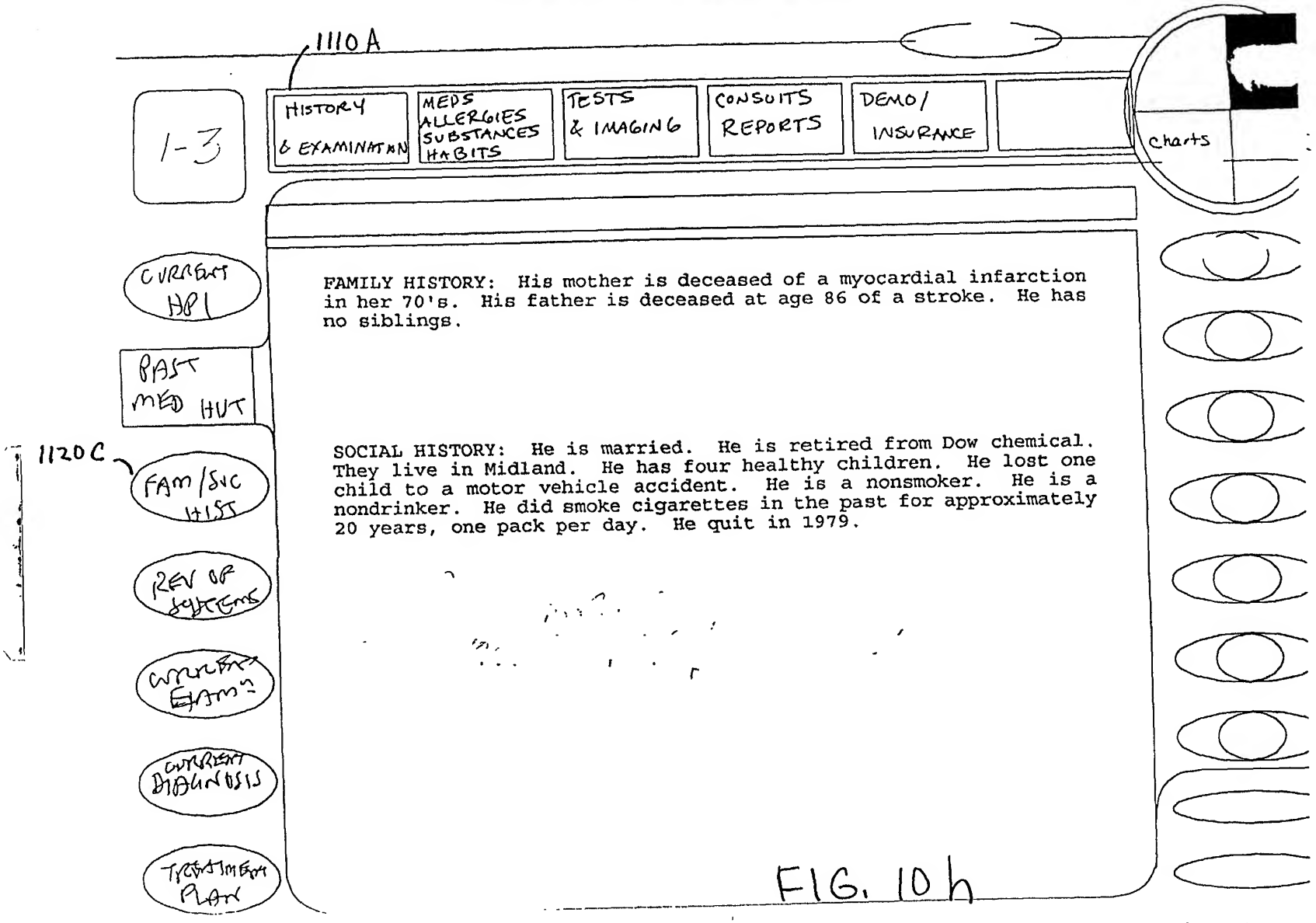


FIG. 10h

Title: MULTIMEDIA COMPUTERIZED PATIENT RECORD SYSTEM
Inventor: Manoucher Gueramy et al.
Atty. Ref. No.: 6766-000004

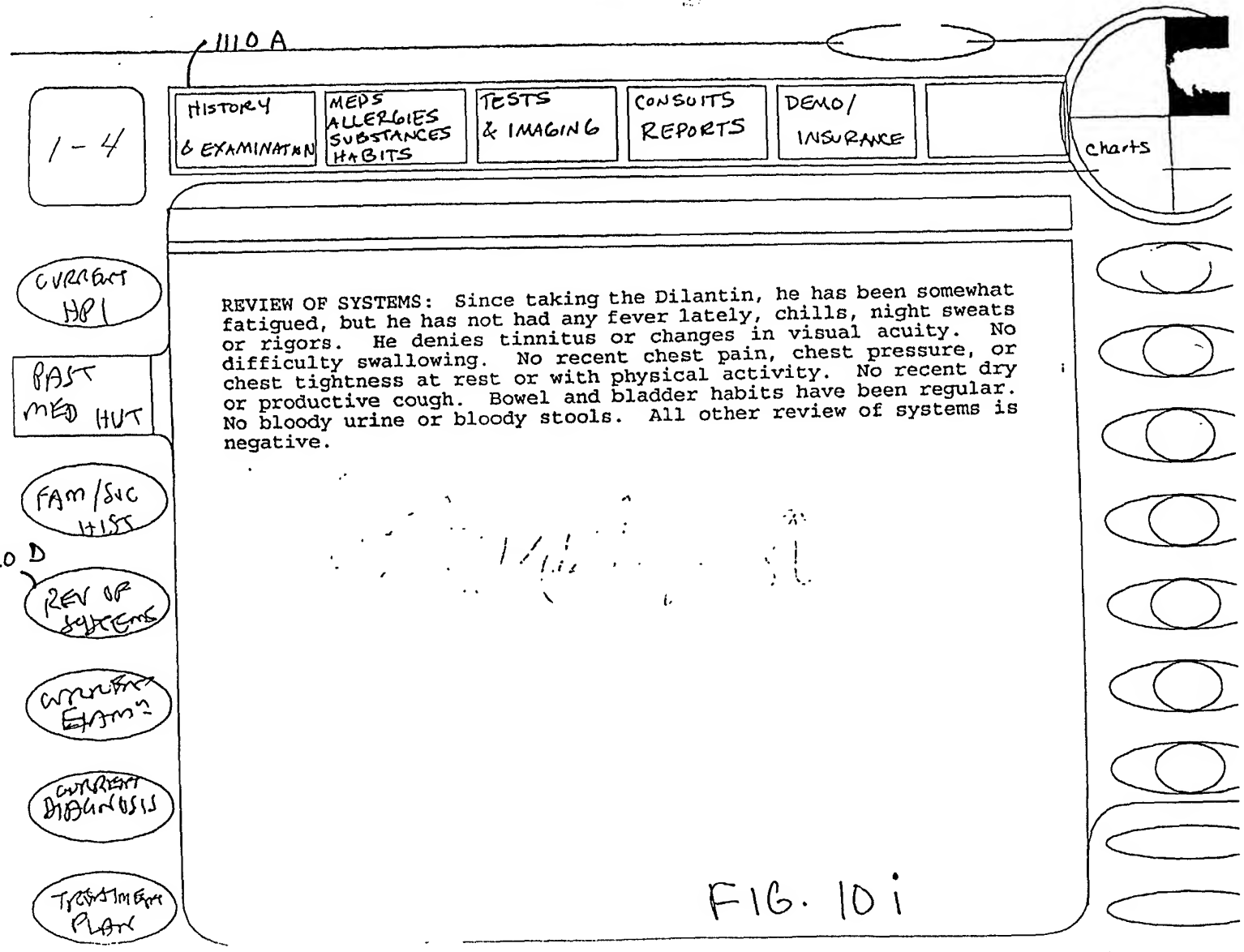

1110 A
1 - 4
HISTORY & EXAMINATION
MEDS ALLERGIES SUBSTANCES HABITS
TESTS & IMAGING
CONSULTS REPORTS
DEMO/ INSURANCE
charts
CURRENT HPI
PAST MED HIST
FAM/SOC HIST
1120 D
REV OF SYSTEMS
CURRENT EXAMS
CURRENT DIAGNOSIS
TREATMENT PLAN
REVIEW OF SYSTEMS: Since taking the Dilantin, he has been somewhat fatigued, but he has not had any fever lately, chills, night sweats or rigors. He denies tinnitus or changes in visual acuity. No difficulty swallowing. No recent chest pain, chest pressure, or chest tightness at rest or with physical activity. No recent dry or productive cough. Bowel and bladder habits have been regular. No bloody urine or bloody stools. All other review of systems is negative.

FIG. 10i

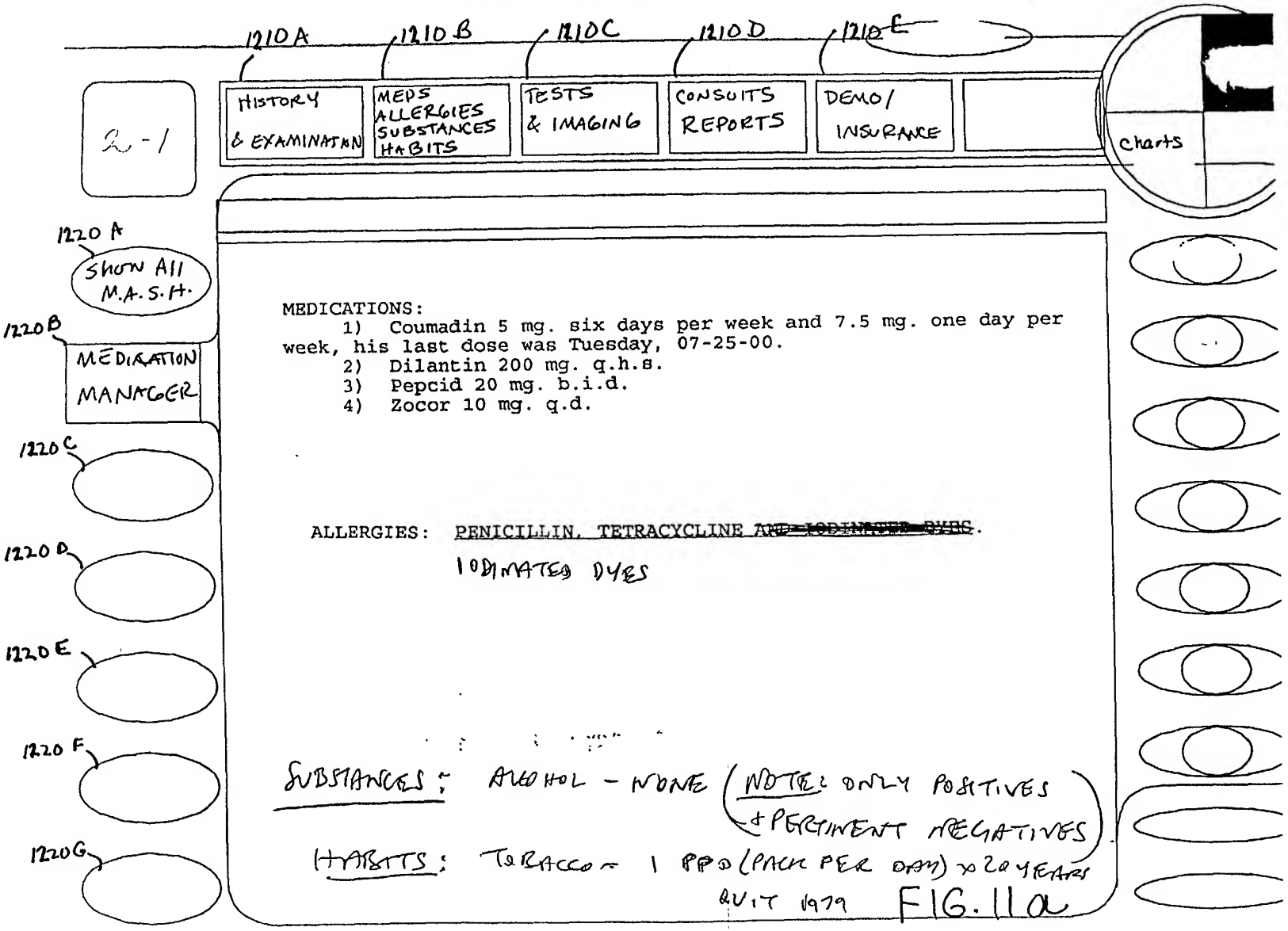


FIG. 11a

Title: MULTIMEDIA COMPUTERIZED PATIENT RECORD SYSTEM
Inventor: Manoucher Gueramy et al.
Atty. Ref. No.: 6766-000004

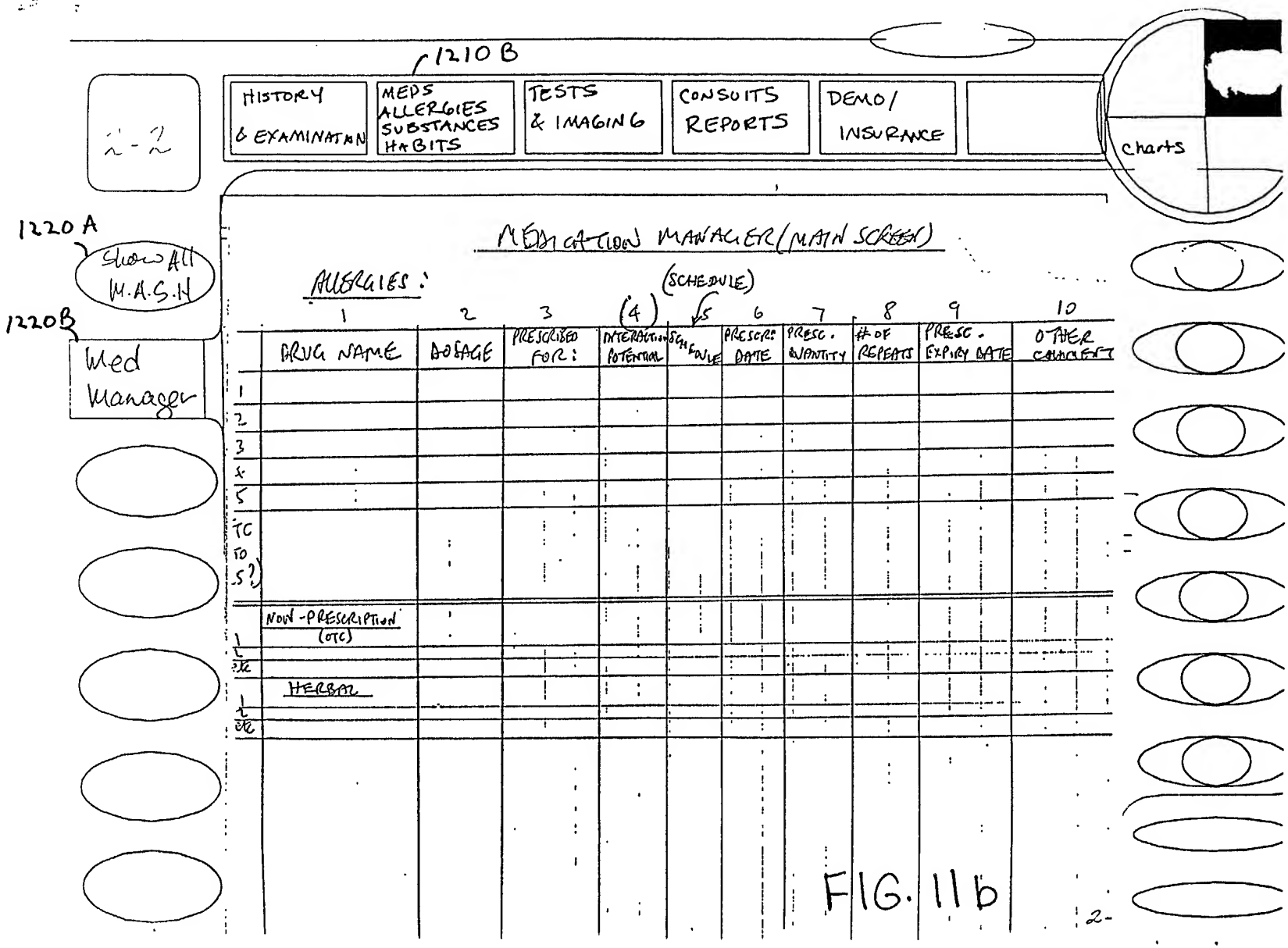

1210 B
HISTORY & EXAMINATION
MEDS ALLERGIES SUBSTANCES HABITS
TESTS & IMAGING
CONSULTS REPORTS
DEMO/ INSURANCE
charts
1220 A
Show All M.A.S.H
1220 B
Med Manager
MEDICATION MANAGER (MAIN SCREEN)
ALLERGIES:
(SCHEDULE)
1 DRUG NAME
2 DOSAGE
3 PRESCRIBED FOR:
(4) INTERACTION POTENTIAL
5
6 PRESCR. DATE
7 PRESC. QUANTITY
8 # OF REPEATS
9 PRESC. EXPIRY DATE
10 OTHER COMMENTS
1
2
3
4
5
TO 5?
NON-PRESCRIPTION (OTC)
HERBAL

FIG. 11b

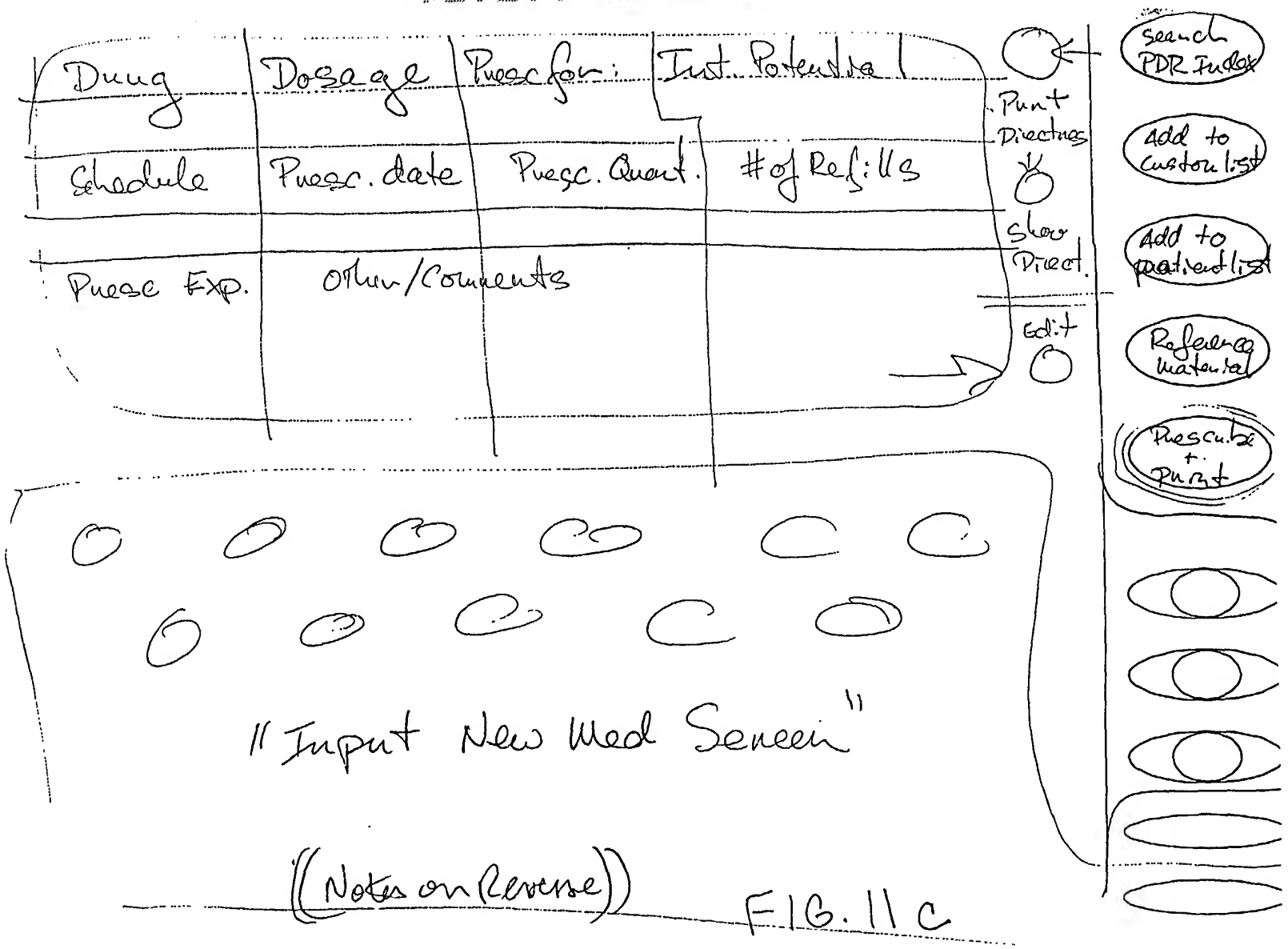

Drug
Dosage
Presc for:
Inst. Potential
Schedule
Presc. date
Presc. Quant.
# of Refills
Presc Exp.
Other/Comments
Print Directions
Show Direct.
Edit
Search PDR Index
Add to custom list
Add to patient list
Reference material
Prescribe + Print
"Input New Med Screen"
((Notes on Reverse))

FIG. 11C

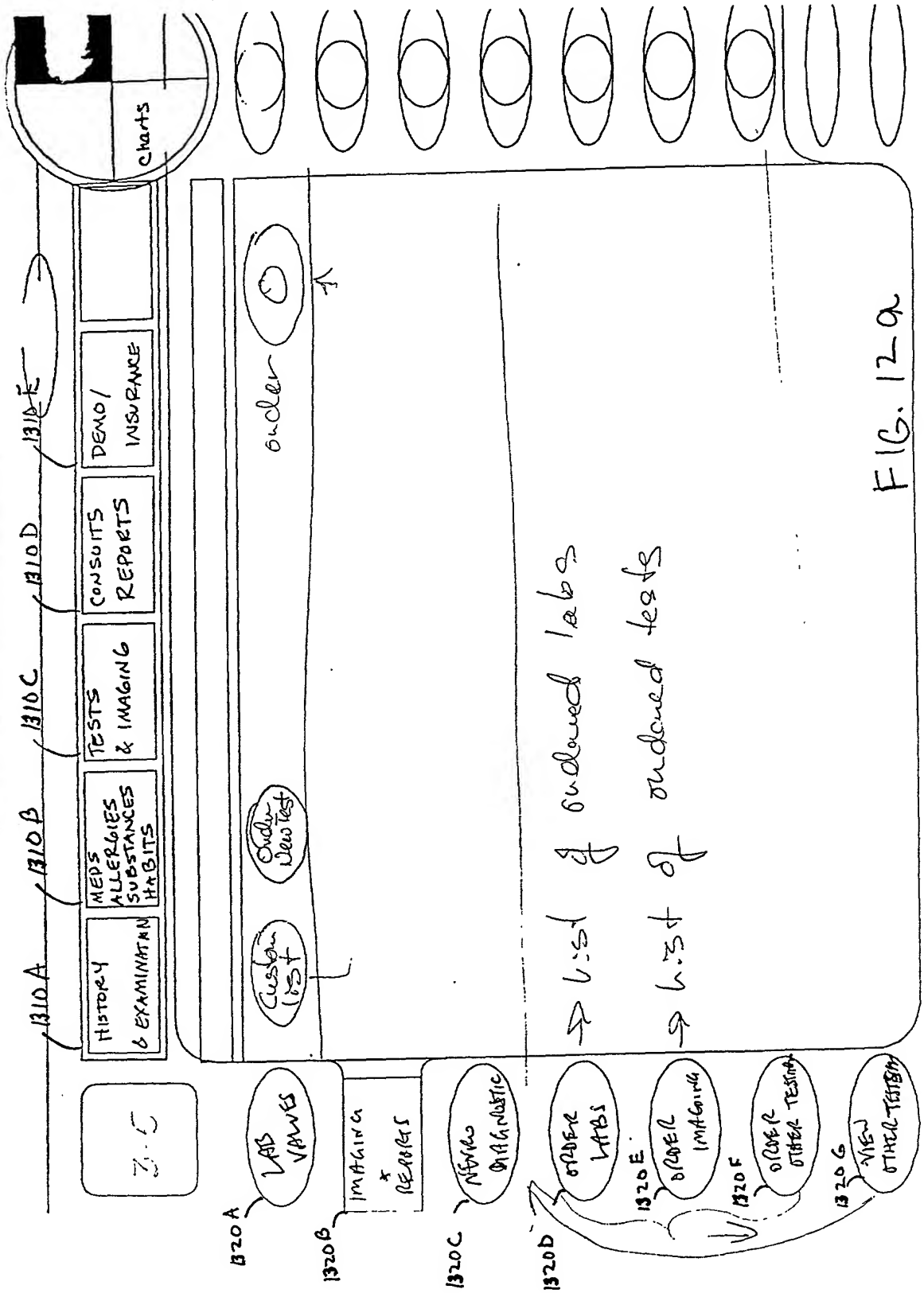

1310A
1310B
1310C
1310D
1310E
HISTORY & EXAMINATION
MEDS ALLERGIES SUBSTANCES HABITS
TESTS & IMAGING
CONSULTS REPORTS
DEMO/ INSURANCE
charts
Custom list
Order Usual Test
order
1320A
LAB VALUES
1320B
IMAGING & REPORTS
1320C
NERVE DIAGNOSTIC
1320D
ORDER LABS
1320E
ORDER IMAGING
1320F
ORDER OTHER TESTING
1320G
VIEW OTHER TESTING
→ list of ordered labs
→ list of ordered tests

FIG. 12A

TEST ORDER SCREEN (GENERIC)

EXIT FEATURE

TEST	INDICATION (S)	TEST DATE	FREQUENCY	DATE NEXT	URGENCY	LOCATION/ COMMENTS
					(STAT) (ROUTINE) (ETC)	

FIG. 12b

Title: MULTIMEDIA COMPUTERIZED PATIENT RECORD SYSTEM
Inventor: Manoucher Gueramy et al.
Atty. Ref. No.: 6766-000004
23/33

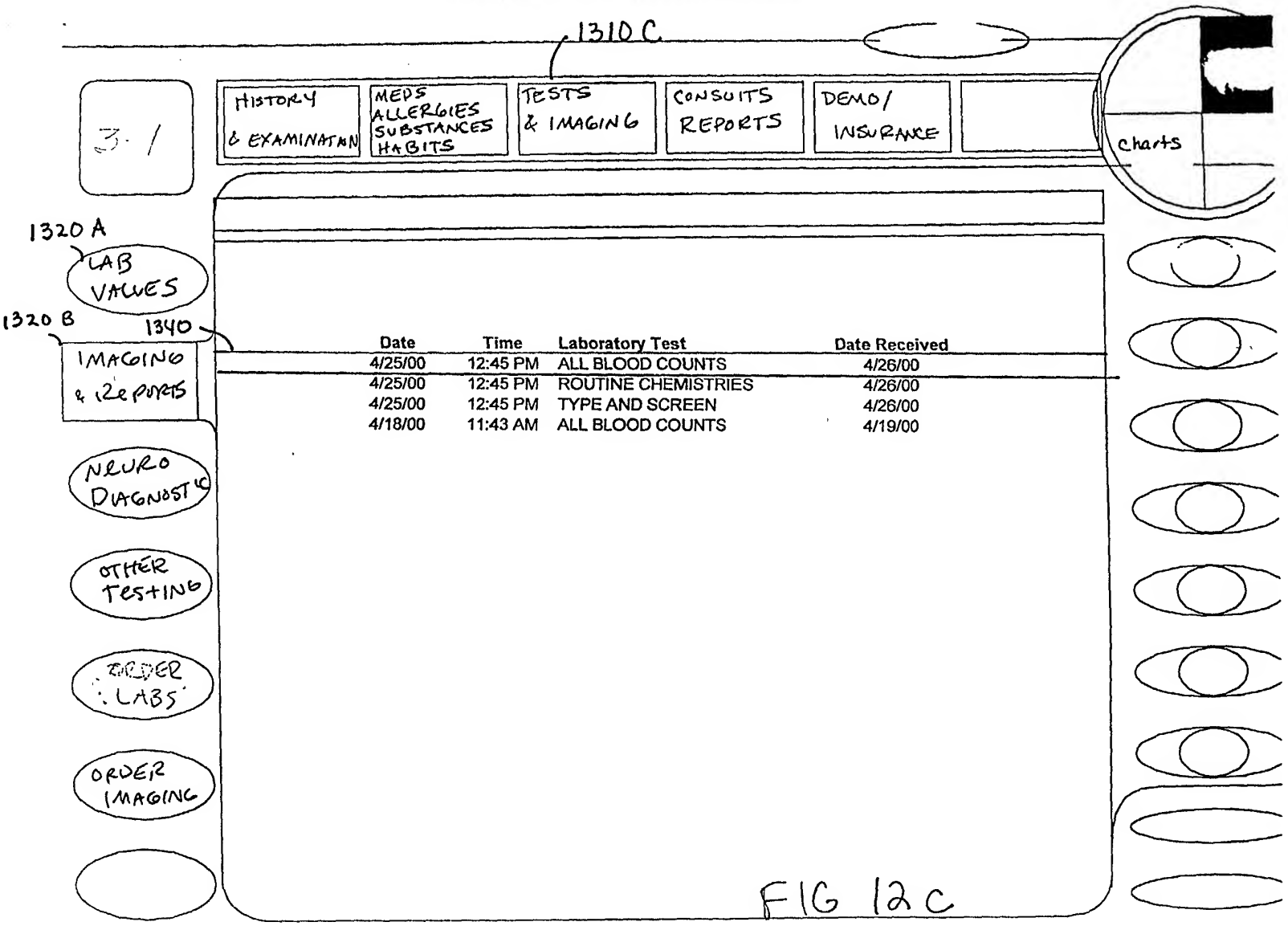

1310 C
HISTORY & EXAMINATION
MEDS ALLERGIES SUBSTANCES HABITS
TESTS & IMAGING
CONSULTS REPORTS
DEMO/ INSURANCE
Charts
3.1
1320 A
LAB VALUES
1320 B
1340
IMAGING & REPORTS
NEURO DIAGNOSTIC
OTHER TESTING
ORDER LABS
ORDER IMAGING
Date Time Laboratory Test Date Received
4/25/00 12:45 PM ALL BLOOD COUNTS 4/26/00
4/25/00 12:45 PM ROUTINE CHEMISTRIES 4/26/00
4/25/00 12:45 PM TYPE AND SCREEN 4/26/00
4/18/00 11:43 AM ALL BLOOD COUNTS 4/19/00

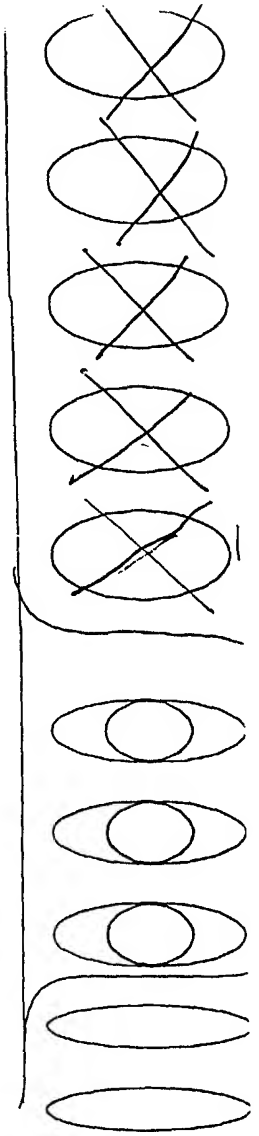
FIG 12C

LAB VALUES

Time: 12:45 PM Date: 4/25/00 Date Received: 4/26/00

Lab Test	Value	Range Normal	Lower	Upper	Units
WBC	9.1		4.8	10.8	K/UL
RBC	5.13		3.6	6.1	M/UL
HGB	15.3		14	18	GM/DL
HCT	45.1		42	48	%
MCV	87.9		80	100	FL
MCH	29.8		27	33	PG
MCHC	33.8		32	37	%
RDW	13		11.5	14.5	%
PLT	277		150	450	K/UL
GRAN	62		42	83	%
LYMPH	22		10	46	%
MONO	7		0	14	%
EO	8		0	5	%
BASO	1		0	2	%

FIG. 12d



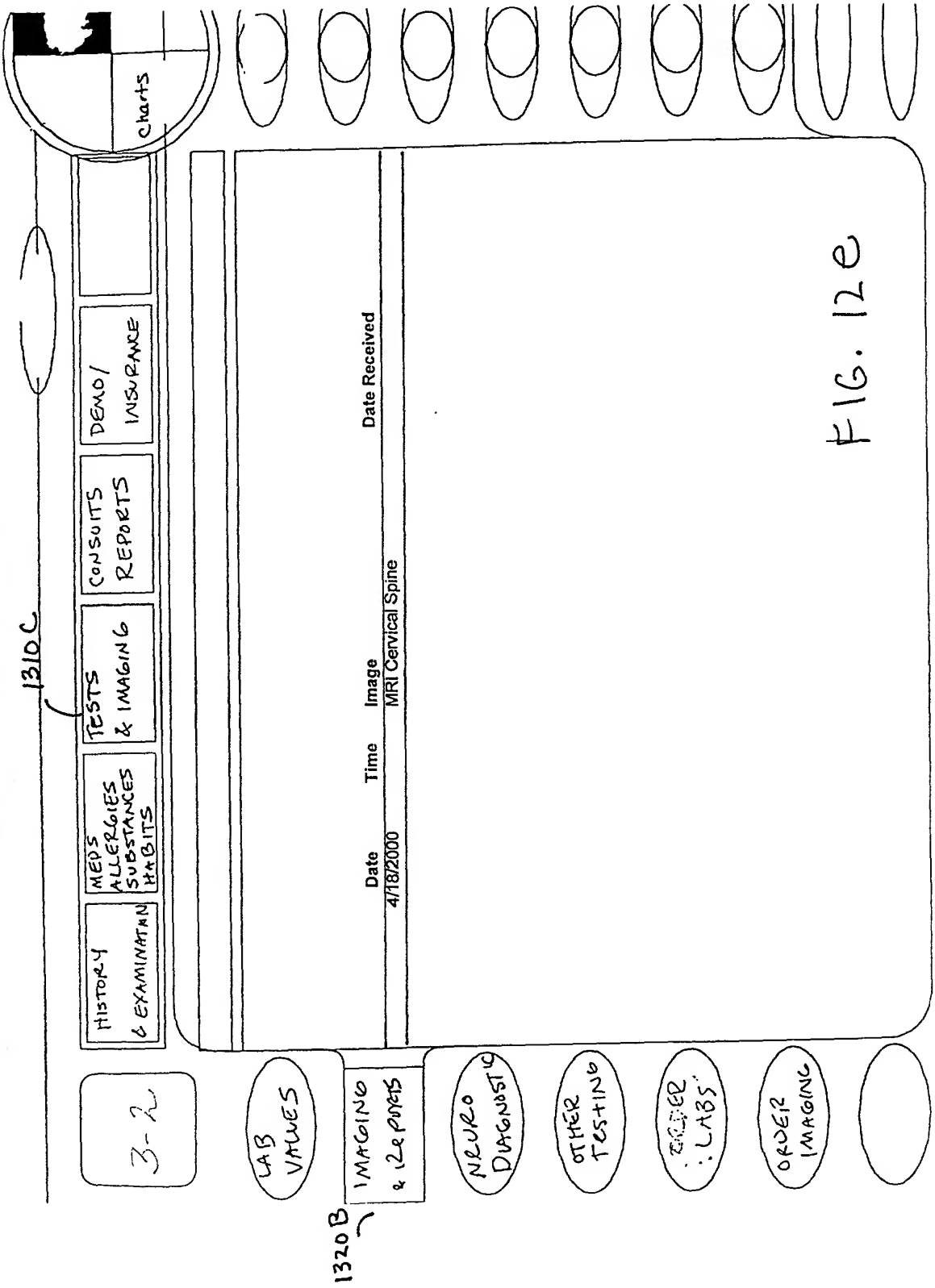

1310C
HISTORY & EXAMINATION
MEDS ALLERGIES SUBSTANCES HABITS
TESTS & IMAGING
CONSULTS REPORTS
DEMO/ INSURANCE
charts
Date
Time
Image
Date Received
4/18/2000
MRI Cervical Spine
3-2
LAB VALUES
IMAGING & EP STUDIES
1320B
NEURO DIAGNOSTIC
OTHER TESTING
ORDER : LABS
ORDER IMAGING

FIG. 12e

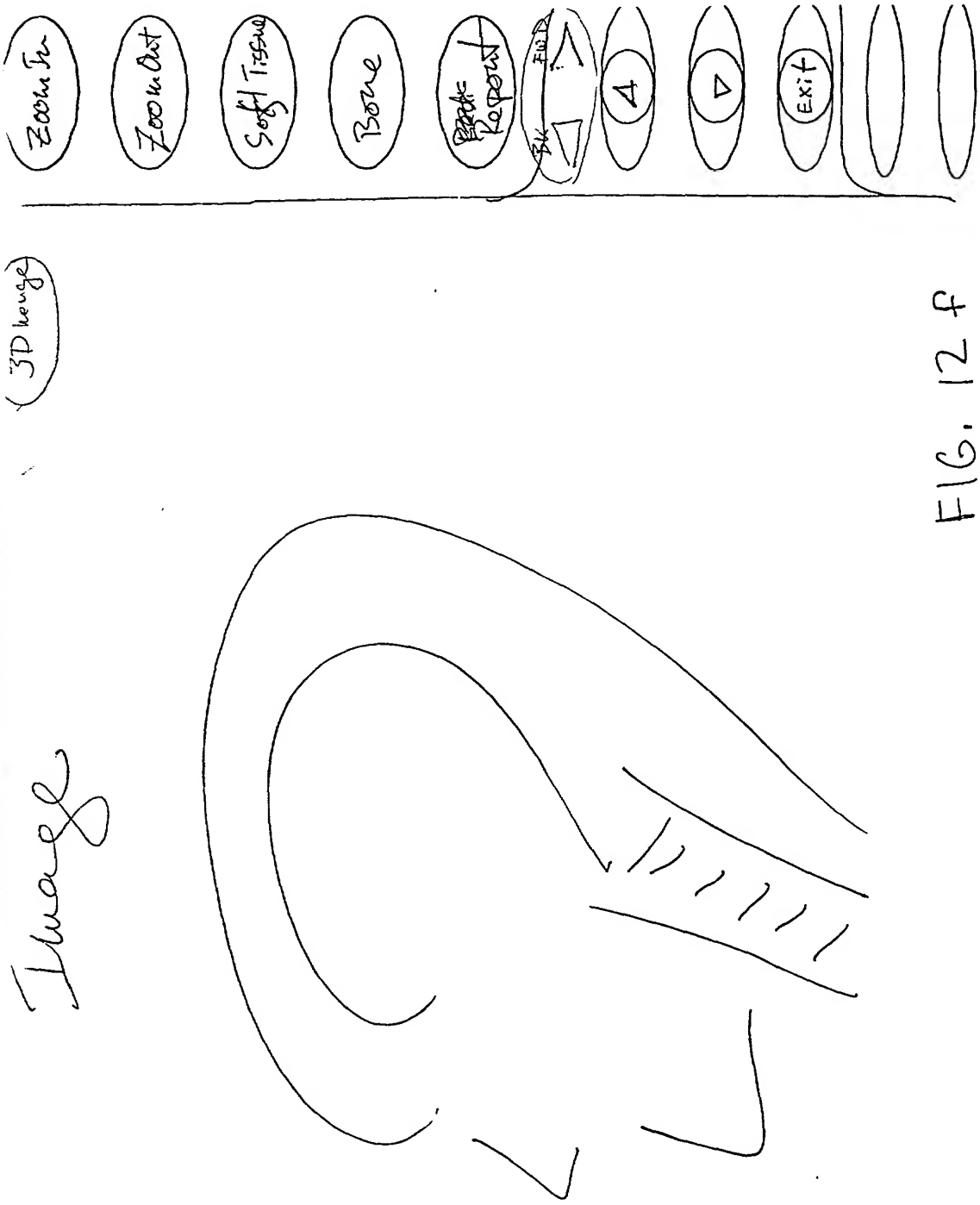


FIG. 12 f

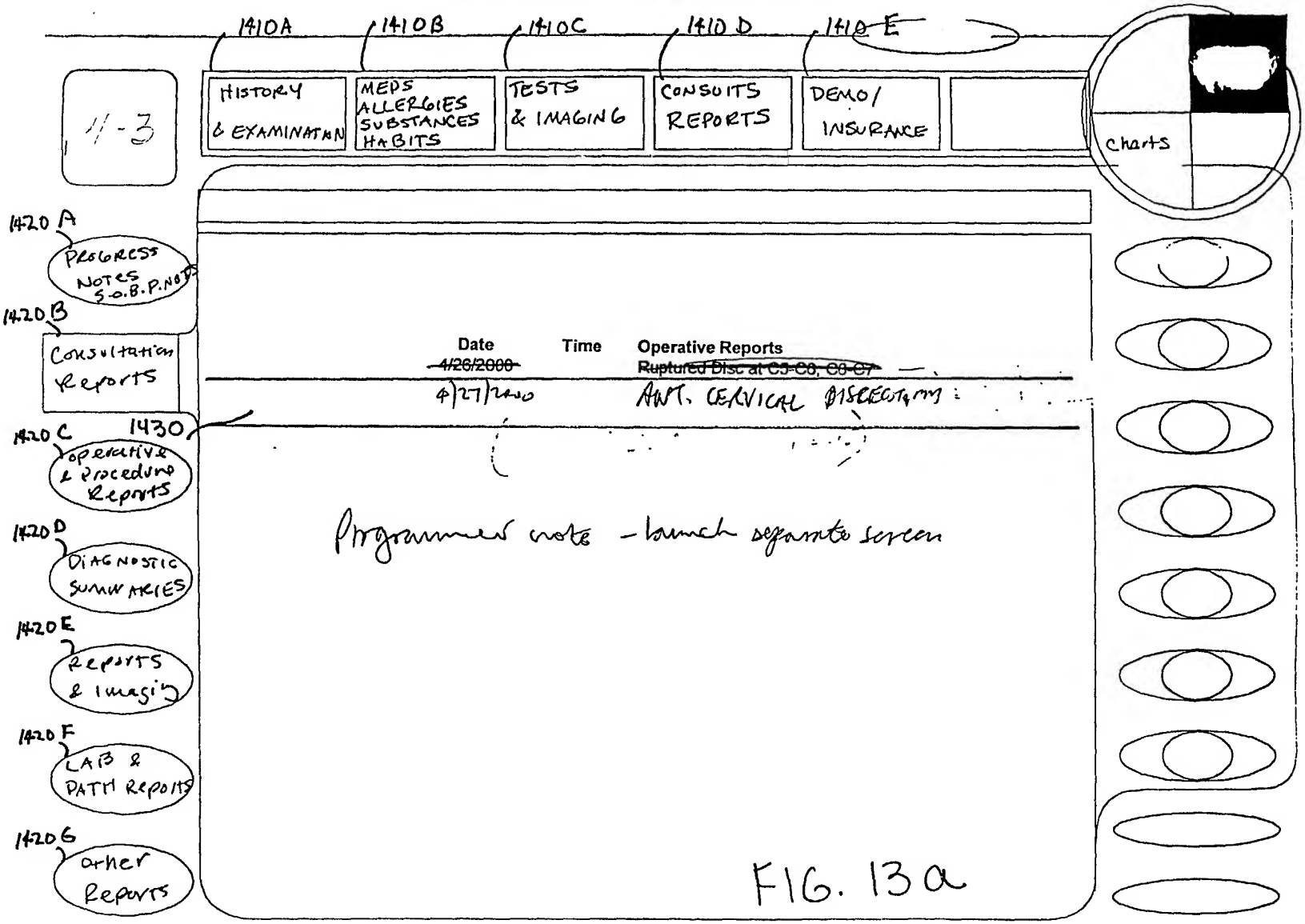


FIG. 13a

Title: MULTIMEDIA COMPUTERIZED PATIENT RECORD SYSTEM
Inventor: Manoucher Gueramy et al.
Atty. Ref. No.: 6766-000004

DATE: 04-26-2000

PATIENT:

→ (Operative Report)

SURGEON: M. D.

PREOPERATIVE DIAGNOSIS: Ruptured disc at C5-C6, C6-C7 with nerve root compression.

POSTOPERATIVE DIAGNOSIS: Ruptured disc at C5-C6, C6-C7 with nerve root compression.

OPERATION:

1) Removal of ruptured disc and decompression of nerve roots and dural sac at C5-C6, C6-C7.

2) Partial corpectomy at C5-C6 and C6-C7 and expansion of disc space and removal of posterior longitudinal ligament and decompression of nerve roots.

3) Interbody fusion using bone from bone bank.

4) Anterior plating using DOC system and 14 mm. screws placed into C4-C5 and C6.

PROCEDURE: The patient was positioned under general anesthesia. Head was slightly turned to the left. The neck was prepped and draped in the usual fashion. An incision was made in one of the creases of the neck. The skin was separated from platysma. The platysma was incised along the border of the sternocleidomastoid and sharp and blunt dissection were carried out. The anterior cervical spine was exposed. The disc spaces at C5-C6 and C6-C7 were identified with the help of x-ray. Then a small amount of methylene blue was injected into the disc spaces. Dissection was done through the anterior longitudinal ligament into disc space. Removal of the ruptured discs was carried out at both levels. Then with the help of a Stryker drill, the disc space was retracted. A partial corpectomy was carried out, and posterior osteophytes were removed. Posterior longitudinal ligament was opened up and removed with the help of Kerrison punch. Nerve roots were decompressed bilaterally. Bone was taken from the bone bank, cut and shaped to the size of the disc spaces and introduced into the disc spaces properly. Then the area was irrigated thoroughly. An anterior plate of proper size was selected and placed and screwed to the anterior surface of C5, C6 and C7 under fluoroscopy control. Then the area was irrigated thoroughly, platysma closed with interrupted 4-0 Vicryl, subcu with 4-0 Vicryl and the skin was closed with Dermabond.

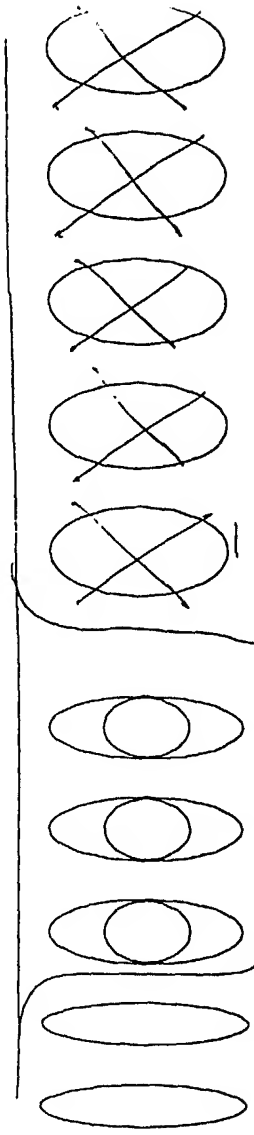


FIG. 13b

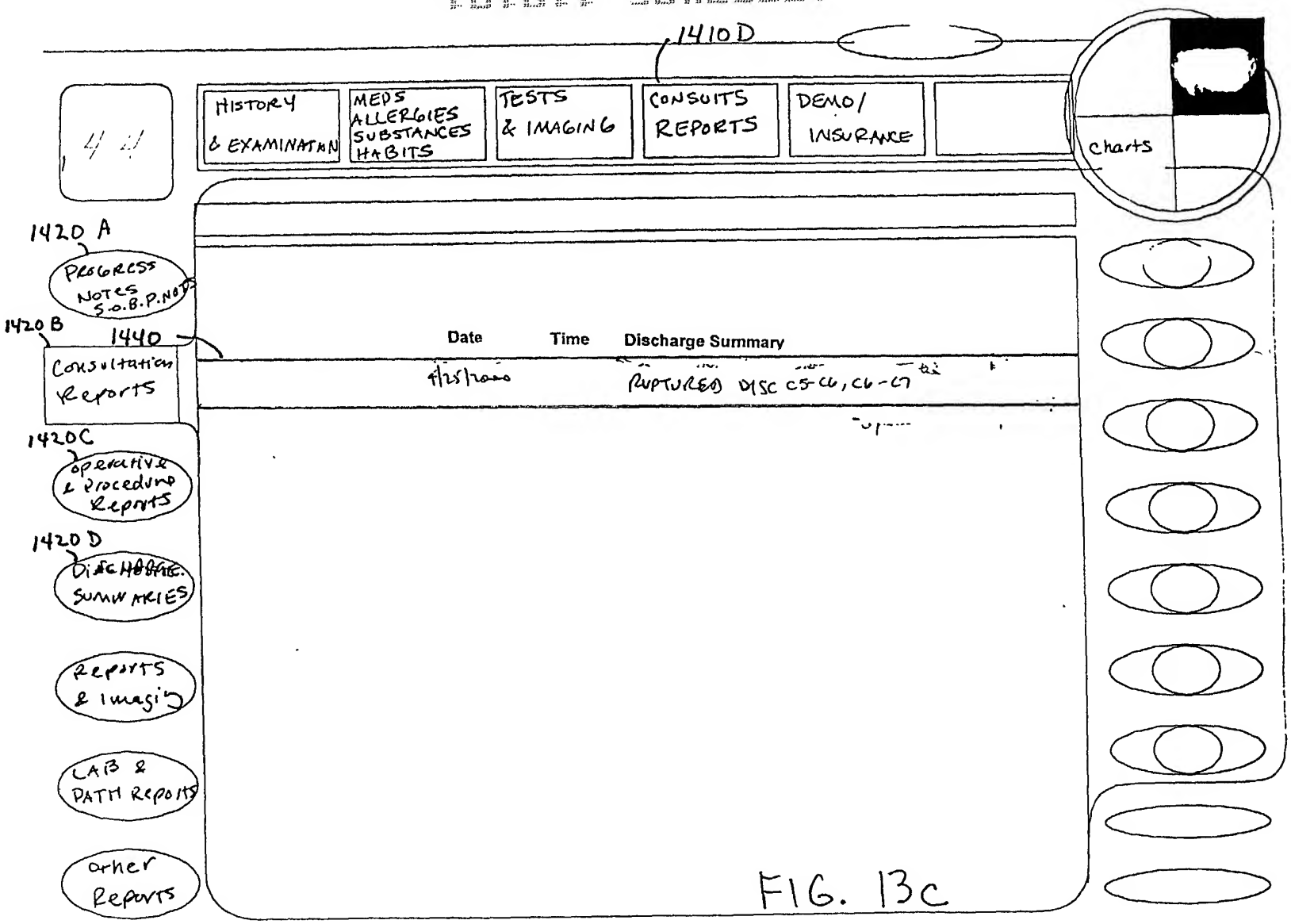

1410D
HISTORY & EXAMINATION
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FIG. 13c

DATE OF ADMISSION: 04-26-2000

DATE OF DISCHARGE: 04-27-2000

PATIENT:

DISCHARGE DIAGNOSES: Status post anterior cervical discectomy with interbody fusion using bone graft from the Bone Bank, C5-C6, C6-C7 levels with anterior cervical plating.

SECONDARY DIAGNOSES:

1) Diverticulosis.
2) Hypertension.

HISTORY OF PRESENT ILLNESS: is a left-handed, 55 year old, Caucasian male, who is admitted with a diagnosis of spondylolytic radiculopathy at C5-6 and C6-C7, as well as a disc herniation at the C5-C6 level and this was confirmed by an MRI of the cervical spine. Treatment options were explored. He elected to proceed with surgery, despite the inherent risks.

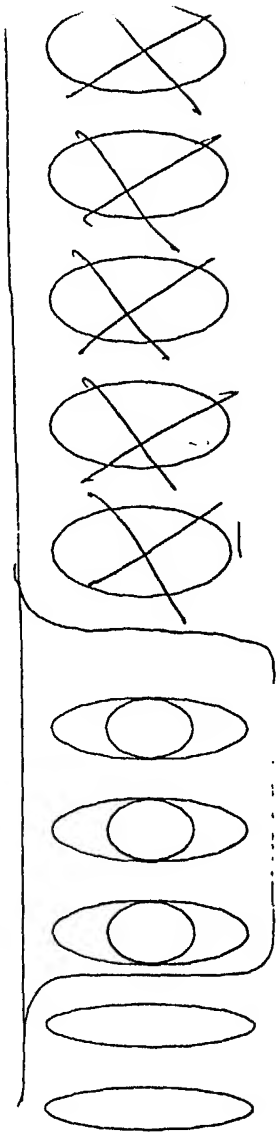
HOSPITAL COURSE: There were no documented intraoperative complications.

Postoperatively, he did well. He had dysesthesias in the left C6-C7 dermatomes. He had no radicular pain in his left or right arm, no cervical pain. Blood pressure remained stable throughout his hospital stay. He never developed a fever. There was no evidence of incisional drainage or infection. He had no new weakness n his upper extremities. Postoperative C-spine radiograph showed excellent position of the bony grafts at the C5-C6, C6-C7 levels, a well as excellent position of the anterior cervical plate. He was discharged home on the first postoperative day in good condition.

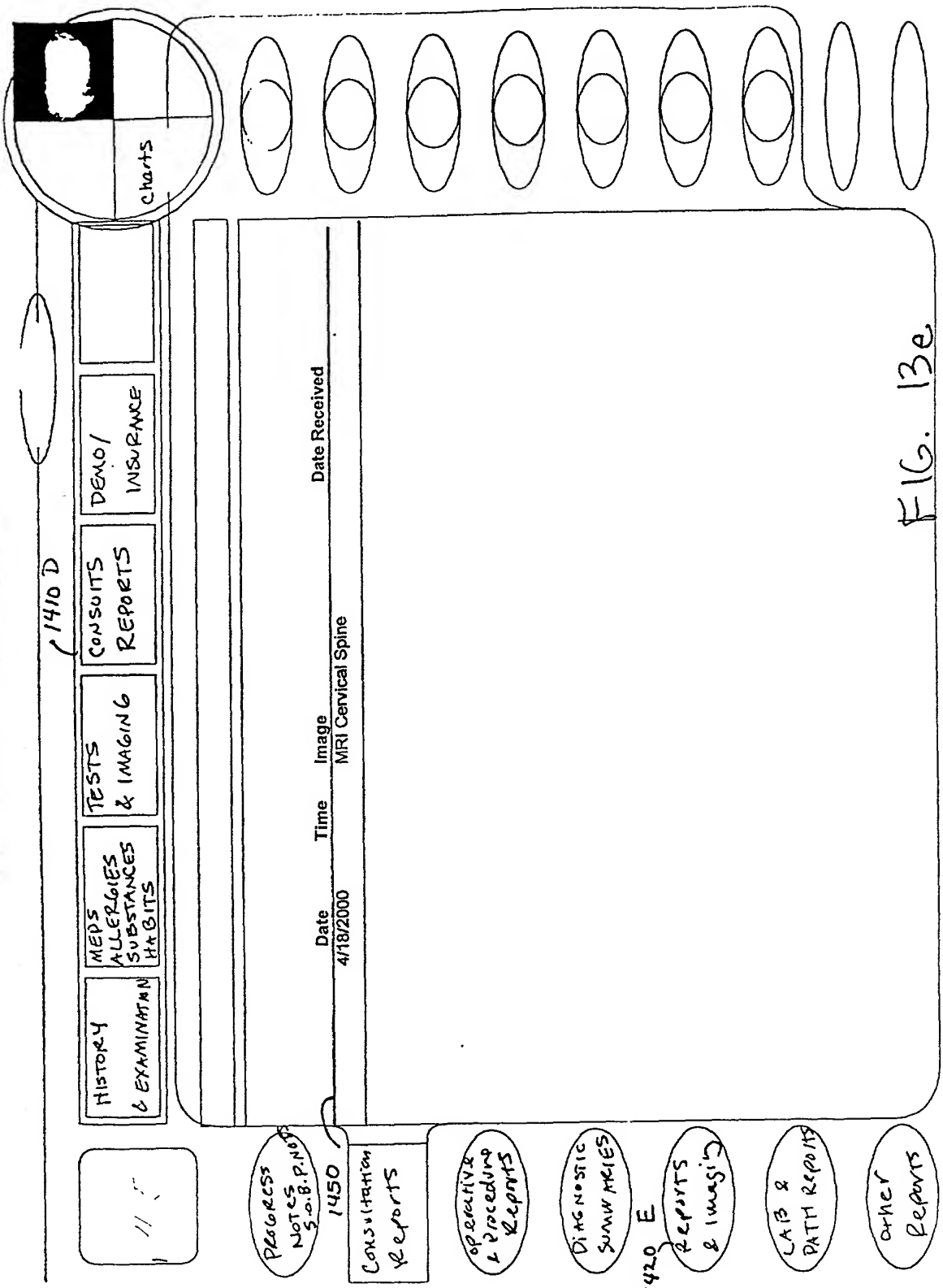
DISCHARGE MEDICATIONS: Medications on discharge.

1) Vioxx 25 mg., q.d. times two weeks.
2) Flexeril mg. q.h.s.
3) Tylenol #3, one to two q 3-4 hr p.r.n. pain.
4) Hydrochlorothiazide per his family physician's recommendation q.d.

FIG. 13d



Title: MULTIMEDIA COMPUTERIZED PATIENT RECORD SYSTEM
Inventor: Manoucher Gueramy et al.
Atty. Ref. No.: 6766-000004
31/33


charts
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HISTORY & EXAMINATION
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Date Received
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Other Reports

FIG. 13e.

NOTE: Could have Image →

HISTORY: RUPTURED DISC C5-C6

MRI CERVICAL SPINE

INDICATIONS: Neck/left shoulder and arm pain.

TECHNIQUE: As per protocol.

COMPARISON: No previous MRI.

FINDINGS: Detail is slightly limited, but diagnostic. The craniocervical junction, C2-C3-C4-C5 levels are normal. Mild facet joint degenerative changes at C4-C5 level noted, however.

C5-C6: Moderate size central and left-sided disc herniation is present with effacement of ventral left CSF space. Minimal degenerative ridging associated.

C6-C7: Mild degree degenerative ridging, but no frank focal disc herniations.

C7-T1 and cervicothoracic junction area normal.

IMPRESSION: Moderate size central and left-sided disc herniation at C5-C6 with mild degenerative ridging.
Mild degree disc degenerative changes at C6-C7 with degenerative ridging, but no focal disc herniation.

M. D.

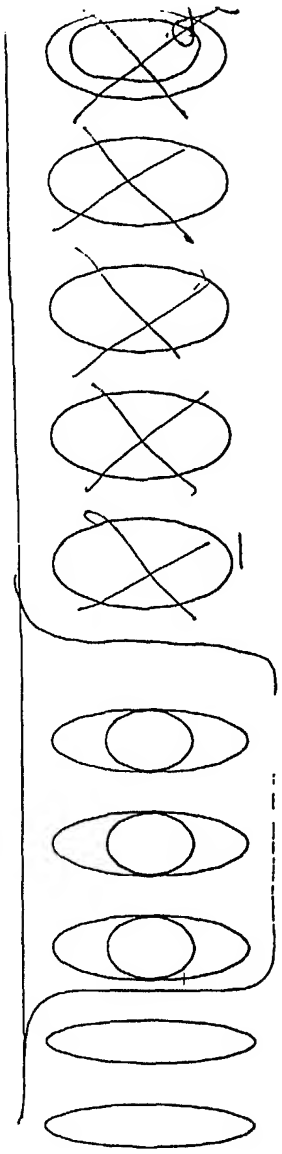

FIG. 13f